Workshop Wednesday

An Introduction to Perinatal Mental Health Awareness and Screening

Maridee Shogren DNP, CNM, CLC

November 17, 2021

SAMHSA
Substance Abuse and Mental Health Services Administration

Mountain Plains (HHS Region 8)
MHTTC Mental Health Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

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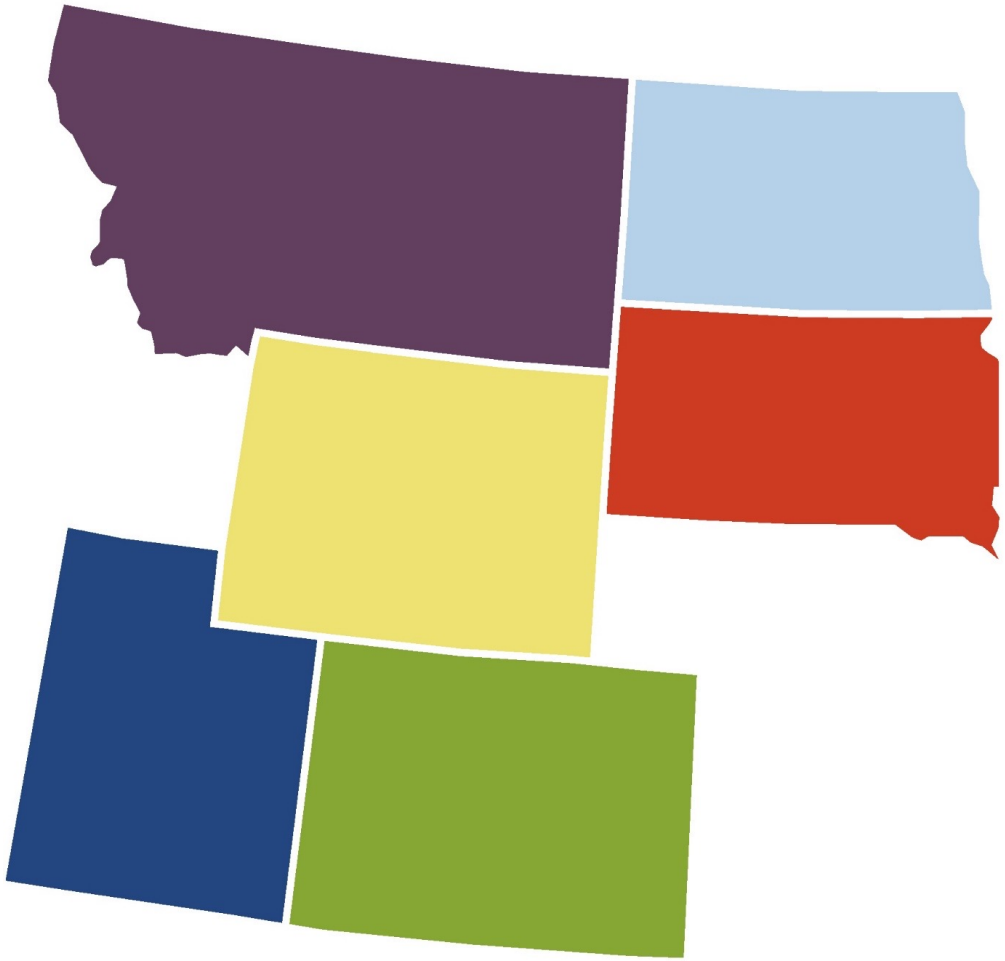
The work of the Mountain Plains MHTTC is supported by grant H79SM081792 from the Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

The Mountain Plains Mental Health Technology Transfer Center

The Mountain Plains Mental Health Technology Transfer Center (Mountain Plains MHTTC) provides training and technical assistance to individuals who serve persons with mental health concerns throughout Region 8 (Colorado, Montana, North Dakota, South Dakota, Utah and Wyoming).

We belong to the Technology Transfer Center (TTC) Network, a national network of training and technical assistance centers serving the needs of mental health, substance use and prevention providers. The work of the TTC Network is under a cooperative agreement by the Substance Abuse and Mental Health Service Administration (SAMHSA).



The MHTTC Network uses affirming, respectful and recovery-oriented language in all activities. That language is:

- Strengths-based and hopeful
- Inclusive and accepting of diverse cultures, genders, perspectives, and experiences
- Healing-centered and trauma-responsive
- Inviting to individuals participating in their own journeys
- Person-first and free of labels
- Non-judgmental and avoiding assumptions
- Respectful, clear and understandable
- Consistent with our actions, policies, and products

Adapted from: https://mhcc.org.au/wp-content/uploads/2019/08/Recovery-Oriented-Language-Guide_2019ed_v1_20190809-Web.pdf

Land Acknowledgement Statement

Today, the University of North Dakota rests on the ancestral lands of the Pembina and Red Lake Bands of Ojibwe and the Dakota Oyate - presently existing as composite parts of the Red Lake, Turtle Mountain, White Earth Bands, and the Dakota Tribes of Minnesota and North Dakota. We acknowledge the people who resided here for generations and recognize that the spirit of the Ojibwe and Oyate people permeates this land. As a university community, we will continue to build upon our relations with the First Nations of the State of North Dakota - the Mandan, Hidatsa, and Arikara Nation, Sisseton-Wahpeton Oyate Nation, Spirit Lake Nation, Standing Rock Sioux Tribe, and Turtle Mountain Band of Chippewa Indians.

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What is Perinatal Mental Health (PMH)?

- Mental Health:
  - A state of well-being
  - Person realizes their abilities and can cope with stressors in life
  - Works productively
  - Contributes to society (Shorey and Chan, 2020)
- Perinatal Period:
  - Time frame that includes pregnancy and ***first year*** postpartum
- Perinatal Mental Health:
  - The state of well-being during the perinatal period

General Background

Pregnancy and parenting are not gender or sex exclusive. When describing findings from research studies, participant population(s) are referred to as they were identified by the researchers who conducted the study. All people who identify with pregnancy and parenting can be affected by mental health challenges during the perinatal period, regardless of gender, sex, or sexual orientation.

Perinatal Mental Health

For years perinatal mental health seemed to be discussed only as postpartum depression

Now we have a better understanding

- A person goes through many hormonal, physical, emotional, and psychological changes during the perinatal period…ALL impact PMH
- PMH does not impact just one person
  - PMH affects many people and potentially many generations

PMH disorders are a spectrum of experiences and conditions

- Include anxiety, depression, psychosis, suicide, perinatal substance use disorders, complicated grief after perinatal loss, and more
- Without treatment PMH disorders can become chronic and persist through more than one pregnancy (MHTTC, 2021)

PMH Stigma May Lead to Lack of Care

- PMH is still stigmatized; many persons are still not coming forward to seek help
  - Stigma may hinder a person's recognition of the presence of PMH distress and may reduce likelihood that they disclose their symptoms to a loved one or health care professional (O'Mahen & Flynn, 2008)
  - Persons report feeling ashamed that their perinatal mental health concerns and symptoms may be seen as signs of personal failure; they fear their social network will disapprove (Fonseca et al., 2018)
- Stigma noted to be the most important barrier to women's help-seeking process (Silva, 2015; as cited in Fonseca et al., 2018)
- Up to 50% of mothers will not seek treatment for PMH concerns (CDC, 2008)
  - Stigma strongly associated with shame, fear of being labeled as "mentally ill" or being judged by health care providers (Bilszta et al., 2010)
    Stigma is enhanced if pregnant person also has a substance use disorder
    - Many report fear of social service or child protection involvement (McLoughlin, 2013)
- Society often has unrealistic, idealized expectations of motherhood (McLoughlin, 2013)
  - Persons may experience guilt for not meeting their OWN expectations of motherhood AND the expectations of others

Perinatal Mental Health Disorders

Perinatal Mental Health Terminology

Postpartum Blues ("Baby Blues"): Mild and short-term mood experience that results after pregnancy and resolves without intervention

Postpartum Depression (PPD): Major depressive disorder that occurs during pregnancy or after delivery

- It is believed that majority of cases of PPD are preceded by depression during pregnancy
- Most experts now argue that the time of onset for symptoms should really be extended through the ***first year*** after delivery (Howard & Khalifeh, 2020)

Perinatal Mental Health Terminology

- **Maternal Perinatal Depression (MPND):** Major depressive disorder with peripartum onset
  - Newer term, more inclusive of the antepartum and postpartum periods
- **Perinatal Anxiety:** Many kinds of anxiety disorders can occur during pregnancy or up to one year after delivery
- **Postpartum Psychosis:** Serious psychiatric illness involving an acute onset of psychotic symptoms in the days or weeks after birth and often requires psychiatric hospitalization
- **Perinatal Suicide:** 5-20% of maternal deaths
- **Perinatal Eating Disorders:** 15% of pregnant persons (MHTTC, 2021)

Multifactorial Risk Factors for PMH Disorders

- Trauma History
  - Adverse childhood experiences (ACES) (Byatt et al, 2020)
  - Includes interpersonal violence, intimate partner violence, perinatal IPV
- Personal history of depression/anxiety/PMS or family history of depression
- Lack of social support
- Higher risk pregnancy:
  - Gestational diabetes, pre-term labor/birth*, pregnancy loss, adolescent parent, multiples
  - Birth complications
- Unplanned or mistimed pregnancy
- Difficult pregnancy or birth experience
- Poverty, lack of financial support
- Substance misuse and substance use disorders (Prevatt et al., 2017)
- Sometimes there may not be significant, identifiable risk factors!

The Baby Blues or Postpartum Blues

- Not considered a disorder; it is the most common experience affecting pregnant persons after delivery
  - Will impact between 50-80% of persons within first 1-2 weeks after birth

- Why do the Blues happen?
  - Biological
    - Hormonal changes after delivery
      - Estrogen and Progesterone decrease quickly by up to 90% over first few days
    - Physiological pain associated with healing, uterus contracting, breast pain with lactation
    - Sleep changes
  - Psychological
    - History of anxiety or depressive disorders or PMS/ significant menstrual cycle mood changes
    - Fear about health and life of infant
    - Uncertainty about change to maternal life (family dynamics, career, financial)
    - Concerned with physical changes (weight, “reduced attractiveness”) (Banasiewicz et al., 2020)

The Baby Blues or Postpartum Blues

- Environmental
  - Support systems and living circumstances
- Symptoms
  - Crying, anxiety, emotional lability (“rollercoaster”), irritability, fatigue and trouble sleeping, lack of interest in food, headaches, concentration problems
  - Usually begin about 3-4 days after delivery, peak within 2-5 days of onset
    - Occasionally symptoms can last longer but symptoms do not tend to worsen
  - Typically, do not interfere with daily functioning

  - **Baby Blues do not progress in severity and resolve on their own within 10-14 days**

Maternal Perinatal Depression (MPND)

- Depression that occurs during/post pregnancy:
  - Antenatal depression (AND): Occurs before birth and
  - Postpartum depression (PPD): Occurs after birth

- MPND is most under-diagnosed obstetric complication in U.S.
(Dagher et al., 2021; PSI, 2021)
  - Affects at least 1 in 7 pregnant persons
  - Estimated that up to 26% of adolescents are affected
    - Some studies have estimated PPD to be as high as 40-60% among teenagers or those of lower socioeconomic status

- Emerging research suggests more persons have developed MPND during the COVID pandemic (~34%)

Maternal Perinatal Depression

- Symptoms are identical to non-perinatal major depression
  - Depressed mood (self-report or observed) present most of the day
  - Anxiety
  - Loss of interest in usual activities or pleasure
  - Changes in sleep patterns
  - Agitation
  - Feelings of worthlessness or guilt
  - Loss of energy or fatigue
  - Inability to concentrate
  - Change in weight or appetite
  - Suicidal ideation, attempt or recurrent thoughts of death

Maternal Perinatal Depression

- Persons with MPND may experience decreased social support, more difficulty with self-care, poor nutrition and weight gain, and increased partner conflict

- MPND is a risk factor for perinatal substance use disorders and vice versa
  - Perinatal depression and anxiety are significantly associated with binge drinking and use of tobacco and other drugs

- Untreated MPND associated with:
  - Higher incidence of preeclampsia
  - Failure to initiate breastfeeding or shortened duration of breastfeeding
  - Maternal suicide (Van Niel & Payne, 2020)

Antenatal Depression

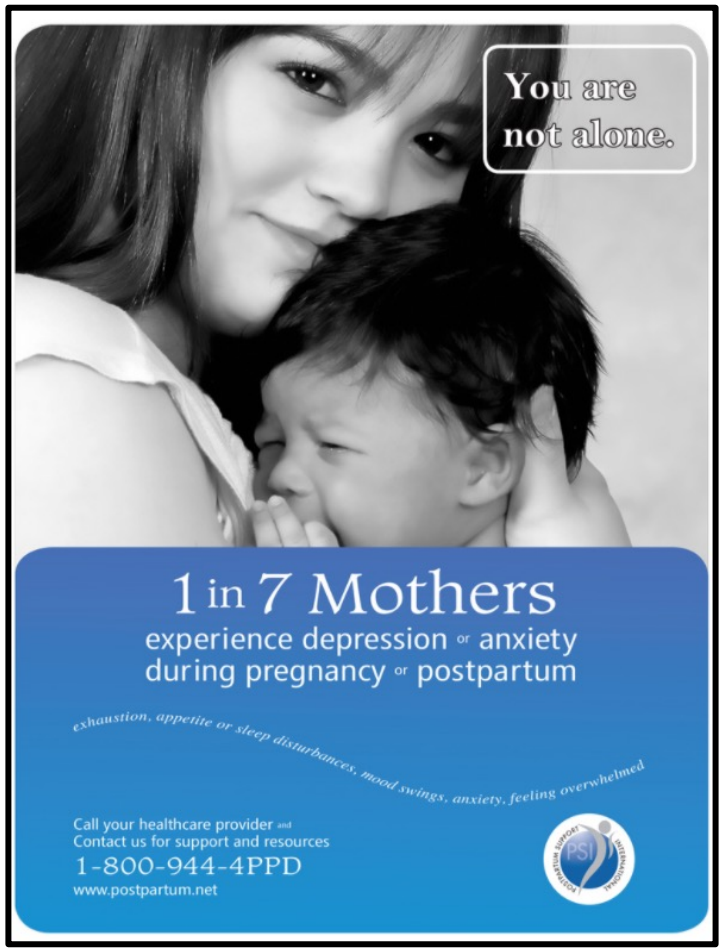
- Less focused on in practice
- Persons often reluctant to share symptoms of sadness because of expectation of happiness during pregnancy
- Higher tendency to focus on physical health during pregnancy
  - Provider and clients may misinterpret depression symptoms as complaints about common discomforts of pregnancy
    - Sleep, body aches, headaches, “pregnancy brain”
      - Worries about previous pregnancy history, complications, and/or losses might trigger more anxiety or depression (Biaggi et. al, 2016)

AND Effects on Infant and Early Childhood

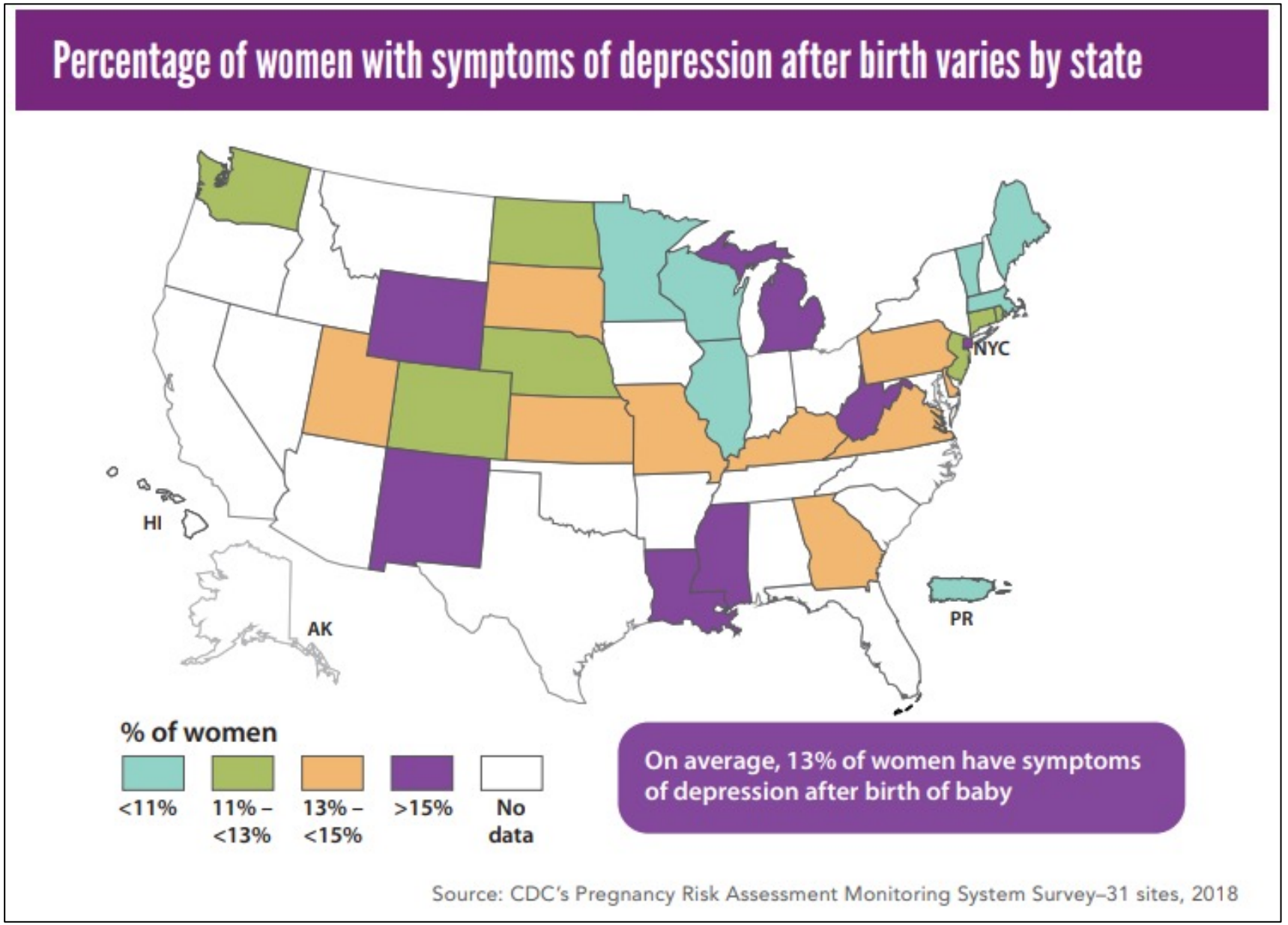
- Depression during pregnancy can impact birth outcomes and exacerbate infant morbidity and mortality
  - 2021 meta-analysis of Antenatal Depression and adverse birth outcomes in U.S. (2010-2020) found that pregnant people with untreated depression were:
    - 1.46x more likely to give preterm birth
      - 2.33x higher risk for African American people
    - 1.9x more likely to deliver a low-birth weight infant
      - 2.47x higher risk for African American people (Simonovich et al., 2021, Van Niel & Payne, 2020)

Postpartum Depression (PPD)

- Affects ALL cultures, ages, incomes, races, & ethnicities
  - First time mothers, & those who deliver prematurely, have higher rates of PPD
    (Banasiewicz et al., 2020)
- 1 in 7 persons will develop
  - ~20% of persons with Baby Blues will develop PPD
- Symptoms usually present within 3 weeks months after birth
  - Peak: 2nd month postpartum
  - Risk remains up to 1 yr postpartum
    - Some evidence suggests the accumulation of stressors in the first year after delivery contributes to the onset or recurrences of depressive episodes
      (Dagher et.al., 2021)
    - Think about all of the changes going on!



PSI, 2021



Retrieved from https://www.cdc.gov/reproductivehealth/vital-signs/identifying-maternal-depression/VS-May-2020-Maternal-Depression_h.pdf

Effects on Infant and Early Childhood

- Associations with MPND imply a complex interplay among genetics, epigenetics, other biological factors, as well as the prenatal and early childhood environment
- Infants and children of mothers with untreated MPND are more likely to have impaired cognitive, behavioral, and emotional development and delayed social and communication skills

- Possible effects include:
  - Attachment insecurity
  - Impaired cognitive, social, emotional development
  - Long-term behavioral problems
  - Newborns
    - Disturbed/disorganized sleep
    - Difficult temperament> may further increase depression
  - Older Children
    - Increased risk for ADHD
    - Behavior and conduct problems
    - Emotional problems: depression and anxiety (persisting into young adulthood)

(Goodman, 2018, Van Niel & Payne, 2020)

Postpartum Psychosis

- Rare: 1-2 out of every 1000 persons who give birth
- Sudden onset of symptoms, typically within 3-10 days after birth, or in first month:
  - Delusions (“break from reality”), Hallucinations (visual, olfactory, tactile), Paranoia
  - Increased irritability
  - Hyperactivity
  - Decreased need for or inability to sleep
  - Rapid mood swings
  - Difficulty communicating at times, confusion
- Risk factors
  - Personal (Strongest single risk factor)/ family history of bipolar disorder or previous psychotic episode, primiparity, advanced maternal age
    - Only 1/3 will present with a prior psychiatric history (Osborne, 2018)
- This is a temporary, treatable condition, but it is an emergency!
  - Early identification, immediate intervention, appropriate treatment are critical to prevent maternal suicide and infanticide (Lisette & Crystal, 2018)

Perinatal Suicide

- Second-leading cause of death among women 25-34y (Admon et al, 2020; Lindahl et al, 2005)
  - Estimated maternal suicide rate of 1.5-4.5 per 100,000 women
    - About 40% of those who complete perinatal suicide have seen a PCP within one month of attempt
    - U.S. does NOT have a good system for identifying maternal deaths from suicide (i.e. some states include accidental overdose in this category); especially beyond first 6 months PP
    - Perinatal persons most frequently complete suicide between 9-12 months postpartum
    - Of those who die by suicide in first 6 months PP, primary diagnoses:
      - 21%-severe depression
      - 31%- substance use disorders
      - 38%- psychosis (Sit et al., 2015)
- ~40% of depressed mothers have reported thoughts of harming the baby
  - Estimated that 1 case of infanticide occurs every 3 days in U.S. (Van Niel & Payne, 2020)

Perinatal Suicide

- Risk factors
  - History of psychiatric illness
    - Those with history of bipolar disorder at higher risk than those with unipolar depression
  - History of suicide attempts
  - Abrupt stopping of psychotropic medications during pregnancy
  - Postpartum sleep disturbances
  - IPV
  - Stillbirth (Lisette & Crystal, 2018; PSI, 2021;Mangla et al., 2019)
  - Possible behavioral clues
    - Decreased responsiveness to infant cues and less infant engagement with mothers
  - Suicidal ideation is a predictor of suicide

Who Else Can Experience Perinatal Depression?

Fathers, Partners, Non-Gestational Parents

- Pregnancy and early parenting can increase vulnerability to psychological distress for BOTH parents
- Paternal Perinatal Depression (PPND) is less researched and not as defined
  - Estimates about 8-25% of fathers will experience PPND (Bruno et al, 2020; Scarff, 2019)
    - Up to 50% if concomitant depression in partner
  - Highest rates occur within 3-6 months postpartum, but can develop over the first year
  - Some may experience “Daddy Blues”
- Limited research suggests
  - Male hormones may shift during pregnancy and after birth too
  - Men also experience changes in sleep and PP sleep deprivation
  - Role strain and role conflict contribute (Shorey and Chan, 2020)
- Male risk factors
  - History of depression
  - Unstable relationships
  - Financial concerns
  - Sick or premature baby; mistimed pregnancy
  - Maternal (partner) depression

(PSI, 2021)

Fathers, Partners, Non-Gestational Parents

- Common paternal PPD symptoms
  - Typically, less sadness than women
  - Fatigue and exhaustion
  - Irritability, agitation, and/or anger
  - Feel of worthlessness; self-criticism
  - Loss of interest in activities that used to bring them joy; restlessness
  - Engagement in risky behaviors like abusing substances
  - Shortness of breath or heart palpitations
- Paternal depression has been linked to concerns that children are at risk for later psychiatric disorders, developmental concerns, and increased risk of emotional/behavioral problems when fathers are depressed
  - Infants might experience higher levels of distress, “sense it”
  - Overall higher risk when both parents were depressed (Bruno et al., 2020; Scarff, 2019)

Fathers, Partners, Non-Gestational Parents

- Less research available regarding experiences of non-gestational and non-biological parents (second parent in a same-sex relationship, multiple parents in a polyamorous family, foster parents, or adoptive parents)
  - One meta-analysis: 3-6 months postpartum had highest rate of depression for partners (Paulson & Bazemore, 2010)
  - Perinatal period may be especially challenging for sexual minority women
    - Additional associated stressors with belonging to a sexual minority group include higher general risk for depression, anxiety, suicidality and substance misuse
    - Stigma and discrimination might increase vulnerability to perinatal depression
  - Greater likelihood of planned pregnancies and more equitable distribution of parenting duties often observed in two-mother families might be protective (Marsland, Treyvaud, & Pepping, 2021)

Adoptive Parents

- Can experience the same types of perinatal mental health issues as other parents and family members (Foli et al., 2016, 2017; Mott et al., 2011)
- About 10-30% of adoptive families may experience postpartum depression
  - This is sometimes called, Post-Adoption Depression (Foli et al., 2017)
- Unique challenges to the transition to parenthood:
  - Loss of gestational experience
    - Family and friends
      - Don’t recognize outward signs of pregnancy or impending parenthood
      - May not appreciate need for and importance of still providing support
  - Stigma
    - Societal approval or disapproval of adoption
  - Uncertain or traumatic adoption process
    - Long wait times
  - Contributing factors often surround expectations
    - Parents, “mothers”, must know how to do this
    - Child
      - Difficulty with attachment, bonding, needs

How Can We Screen for Perinatal Depression Symptoms?

Screening: A Missed Opportunity

- The **United States Preventive Services Task Force**
  - Recommends all adults be screened for depression, including pregnant and postpartum women, and that clinicians provide or refer pregnant and PP women who are at increased risk to counseling
- The **American College of Obstetricians and Gynecologists**
  - Recommends obstetric care providers screen patients for depression and anxiety symptoms at least once during the perinatal period and conduct a full assessment of mood and emotional well-being during the comprehensive postpartum visit
- The **American Academy of Pediatrics**
  - Recommends routine screening for maternal postpartum depression be integrated into well-child visits (Bauman et al., 2020; Van Niel & Payne, 2020)

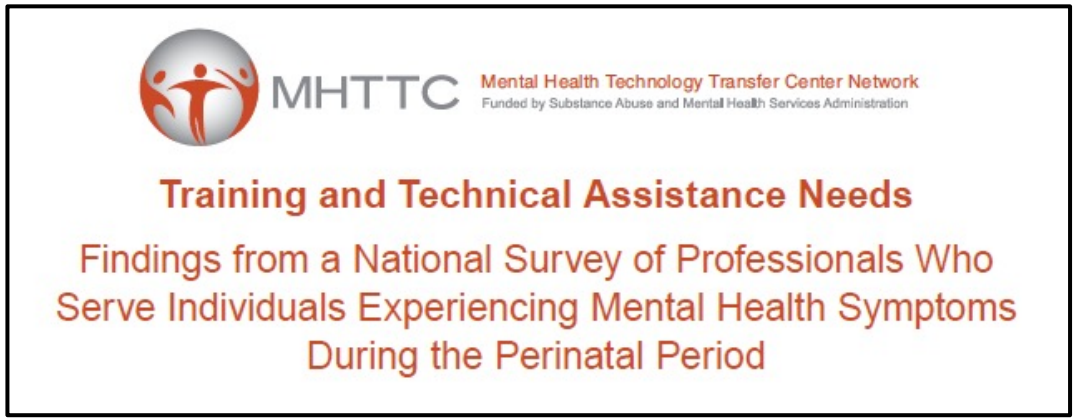
However… According to the CDC

- About 1 in 5 people were not asked about symptoms of depression during a prenatal visit
- 1 in 8 were not asked during a postpartum visit
- As a result:
  - 50-70% of persons with MPND continue to go undetected
  - 85% of persons with MPND continue to go untreated

(CDC, 2020; Dagher et al., 2021; PSI, 2021)

MHTTC National Survey of Professionals: Preliminary Data

- December 2020
  - MHTTC completed a needs assessment to gauge training and technical needs r/t PMH concerns and disorders
  - 579 respondents
    - 46 U.S. states
    - 3 U.S. territories
    - 2 non-U.S. countries



- 2/3 of respondents indicated having at least some prior training about PMH Disorders
  - Few (<20%) reported previous clinical practice experience with identification and treatment of PMHD

MHTTC National Survey of Professionals: Preliminary Data

- The top three most frequently endorsed persons that respondents felt should be responsible for screening of PMH disorders, were
  - Obstetric providers
  - Primary care providers
  - Mental health providers

- Only half of respondents indicated they were screening for PMH disorders in current practice setting
  - 55% use Edinburgh Postnatal Depression Scale
  - 50% use Patient Health Questionnaire-9
  - 22% inquire about mental health symptoms without using a formal assessment tool

MHTTC National Survey of Professionals: Preliminary Data

- For those who indicated that they do not screen for PMHD, and were asked why, 59% stated it was because they lack experience with screening

- When asked about desired training needs:
  - 82% of respondents felt that webinar training was their top training need
  - 65% wanted more information on evidence-based treatment protocols
  - 53% desired information on validated screening tools

Perinatal Depression Screening Tools

Screening for Perinatal Depression

Who & How to Screen?

- Healthcare providers are encouraged to screen ALL perinatal clients for depression
  - Providers shouldn't "Pick and Choose" based on appearance or bias
  - Asian women were 19% less likely, African-American women 36% less likely, and Native American and multiracial women were 56% less likely to be screened
- Providers should use a screening tool to help ask appropriate questions
  - Edinburgh Postnatal Depression Scale
  - PHQ-9

Examples of When to Screen

- First prenatal visit
- At least once in the third trimester; second trimester also appropriate if concerns
- Postpartum visits
  - 2weeks
  - 6+ weeks
- Well-woman/Primary Care visit 1 year after delivery
- Newborn/pediatric appointments!
  - 3, 9, 12-month visits

(PSI, 2021)

Edinburgh Postnatal Depression Scale (EPDS)

- Most frequently used in research settings and clinical practice
- Translated into 50 languages
- Cross-culturally validated
- 10 self-reported questions that are health literacy appropriate
  - Takes 2-3 minutes to complete
  - Includes anxiety symptoms
  - Excludes changes in sleeping patterns which are common in pregnancy and postpartum
- Sensitivity and Specificity range from 70-88%
- Many studies found that the EPDS is twice as effective as a clinician's interview in detecting depression (Van Niel & Payne, 2020)

Edinburgh Postnatal Depression Scale

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

SCORING

QUESTIONS 1, 2, & 4 (without an *)
Are scored 0, 1, 2 or 3 with top box scored as 0 and the bottom box scored as 3.

QUESTIONS 3, 5-10 (marked with an *)
Are reverse scored, with the top box scored as a 3 and the bottom box scored as 0.

Maximum score: 30
Possible Depression: 10 or greater
Always look at item 10 (suicidal thoughts)

Cox, J., Holden, J.M., & Sagovsky, R. (1987). Detection of postnatal depression: Development of the 10-item Edinburgh postnatal depression scale, Br. J. Psychiatry, 150(6), 782-786

PHQ – 9

Kroenke, K., Spitzer, R. L., & Williams, J. B. (2001).

Screens for major depression

Inquires about the most common physical symptoms and includes questions pertaining to mood, anxiety, and sleep

Considered a reliable and valid measure of depressive symptom severity

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

ID #: _____ **DATE:** _____

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

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

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

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 _____

PHQ – 9

Kroenke, K., Spitzer, R. L., & Williams, J. B. (2001).

PHQ-9 Patient Depression Questionnaire

For initial diagnosis:

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

Consider Major Depressive Disorder

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

Consider Other Depressive Disorder

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

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

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

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

Scoring: add up all checked boxes on PHQ-9

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

Interpretation of Total Score

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

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One More Tip!

- When screening:
  - Don’t forget to talk to mothers about their birth experience!
  - Ask them:
    - How did it go?
    - What surprised you?
    - Was labor what you expected?
    - How are you feeling about motherhood?

Don’t Throw Away The Wrapper…..

Treatment for Maternal Perinatal Depression

- Upon a positive screen, clients should undergo addition clinical evaluation to make an appropriate diagnosis
- MPND does not usually resolve without treatment
  - MPND can become a chronic disorder that persists through more than one pregnancy (Meltzer-Brody & Steube, 2014)
  - Symptoms can worsen quickly!
- Treatment options often include a combination of
  - Education
  - Counseling
    - Psychotherapy often first line treatment for mild to moderate MPND
  - Medication (antidepressants)
    - Many options, even with breastfeeding!
    - First choice for severe depression (Goodman, 2018)
  - Support from others
    - Peer support
    - Family support
  - Exercise & a healthy diet
  - Adequate sleep
  - Relaxation techniques

Please Consider the Recovery-Oriented Principles

- Health and mental health providers are encouraged to align their care with the recovery-oriented principles to help provide person-centered, non-stigmatizing care to people with or at risk of developing perinatal mental health disorders (MHTTC, 2021*)
  - Recovery is defined as “a process of change through which individuals improve their health and wellness,
    live a self-directed life, and strive to reach their full potential” (SAMHSA, 2020)
  - Recovery-oriented care, which promotes health and resilience, can help individuals coping with perinatal mental health disorders manage their symptoms successfully
  - Through the Recovery Support Strategic Initiative, SAMHSA has delineated four dimensions and 10 guiding principles that support a life in recovery. These can be found at: https://store.samhsa.gov/sites/default/files/d7/priv/pep12-recdef.pdf

* The document, “Perinatal Mental Health: Considerations for Health and Mental Health Professionals”, developed by the MHTTC Perinatal Mental Health Coordination Group (2021) will be available soon!

Questions

Resources

Postpartum Support International:
PSI Coordinators are volunteers who offer caring and informed support and resources to moms and their families. They also provide information and resources for area providers who are caring for pregnant and postpartum families.

- Certification in Perinatal Mental Health is available for health care professionals with prescribing privileges and affiliated professionals
- https://www.postpartum.net/professionals/certification/

National Suicide Prevention Lifeline
https://suicidepreventionlifeline.org/

Suicide Prevention Resource Center
https://www.sprc.org/

National Suicide Hotline –
1-800-273-8255

Resources

- The American College of Obstetricians and Gynecologists. (2018). ACOG Committee Opinion Number 757: Screening for Perinatal Depression

https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2018/11/screening-for-perinatal-depression.pdf

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Thank You for Joining Us Today!

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November 17, 2021

Mountain Plains (HHS Region 8)
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Funded by Substance Abuse and Mental Health Services Administration

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