Maternal Depression

Linda Welp, RN, BSN, CCCE
Manager, Maternal Child Programs
Community Health Services
Broward Health

June 9, 2017
Objectives

At the completion of this training:

1. You will be able to identify at least five symptoms of maternal depression.
2. You will be able to identify at least five risk factors for maternal depression.
3. You will be able to explain two common treatments for maternal depression.
4. You will be able to name at least three resources for maternal depression.
Perinatal Depression is the most common complication of childbirth

Up to 20% of pregnant women will experience moderate to severe symptoms of depression and anxiety
Postpartum depression is the most under-diagnosed obstetrical complication in the United States. (Ehlers, 2010)
Up to 21% will experience postpartum depression (PPD)

10% of fathers will experience postpartum depression

- #1 risk factor is the Mom having PPD
PMAD – Perinatal Mood and Anxiety Disorders

- Types of PMAD:
  - Blues
  - Depression
  - Anxiety/Panic
  - OCD
  - Bipolar
  - PTSD/Trauma
  - Psychosis
Baby Blues

80% of women get the Baby Blues after childbirth and this is considered normal. Symptoms usually include mood swings, crying spells, anxiousness and irritability, usually last a few days, and get better within 1 – 2 weeks without any treatment.
Depression

- During pregnancy – antepartum or prenatal depression
- After pregnancy – postpartum depression
Anxiety/Panic

- Women experience extreme worries, fears, panic attacks
- Often over health of baby
- Shortness of breath, chest pain, dizziness, losing control
OCD

• Repetitive, unwanted, upsetting mental images (obsessions)

• Need to do things over and over (compulsions) to reduce anxiety

• Women finds these thoughts very scary and unlikely that they will act on them
Bipolar

- Lows – called depression
- Highs – called mania
- Often first diagnosed during pregnancy or postpartum
PTSD/Trauma

- Past trauma
- Traumatic childbirth
- Anxiety /avoid anything related to the traumatic event
Postpartum Psychosis

- Is rare: occurs in 1 – 2 of every 1,000 deliveries
- Onset is sudden, most often within first two weeks postpartum
- A woman experiencing psychosis has had a break with reality
- Hallucinations, violent thoughts, extreme mood swings
- Risk of hurting themselves and their babies

www.postpartum.net
Now let’s talk specifically about maternal depression
Maternal Depression

- Can occur during pregnancy and up to one year after having the baby

- Commonly starts 1 – 3 weeks after childbirth
Maternal Depression

- 10% of pregnant women develop prenatal depression.

- Symptoms are more than the baby blues - moodiness, crying, anxiousness and irritability develop into something more serious called postpartum depression.
Causes

No single cause, likely results from a combination of factors, these are just a few probable ones:

- Hormonal changes – hormones directly affect the brain chemistry that controls emotions and mood.
- History of depression/family history of depression
- Stressful life events
- Lifestyle changes
- Fatigue
Symptoms

- Sleeping too much or too little, insomnia
- Feeling tired all the time
- Eating too much or too little, not wanting to eat foods you enjoy
- Loss of interest in activities you used to enjoy
- Trouble concentrating or making decisions
- Trouble coping with everyday life
- Mood swings
Symptoms continued

- Anxiety about your baby’s well-being or loss of interest in your baby
- Trouble taking care of yourself or your baby
- Nervousness, irritability, anger
- Guilt, sadness, despair
- Helplessness, hopelessness
- Difficulty bonding with your baby
Symptoms continued

- Unusual weight gain or loss
- Loss of interest in sex
- Withdrawal from friends and family
- Unusual weight gain or loss
- Panic attacks
- Thoughts of or fears of hurting yourself or your baby
- Thoughts of death and suicide
Psychological Changes

- Loss of freedom/feeling tied down
- Loss of control
- Loss of body image/self esteem
- Hormonal changes
- Loss of financial means/career potential
- Renegotiating responsibilities and relationships
- Role transitions/”I miss us”
Risk Factors

- Personal or family history of depression, anxiety or postpartum depression
- Lack of or insufficient support in caring for baby
- Marital stress, poor relationship quality
- Single status
- Financial stress
- Complications with pregnancy, birth, baby
- NICU Moms
Risk Factors continued

- Moms of multiples
- Major life event like death of family member/close friend, loss of job, divorce/separation, house move, adoption, pregnancy loss
- Women with medical conditions like diabetes, thyroid, premenstrual dysphoric disorder, infertility and infertility treatments
- Women living in poverty
- Smoking/Substance Use
Risk Factors continued

- Breastfeeding problems like nipple pain
- Pregnant teens and parenting teens
- Military
- Women experiencing abuse, domestic violence, intimate partner violence
- Unintended pregnancy
- Medicaid insurance
- Lower education
One of Healthy People 2020 objectives is to decrease the proportion of women delivering a live birth who experience postpartum depressive symptoms (PDS).

What causes perinatal mood and anxiety disorders? Why did I get this?

There is no one cause for perinatal mood and anxiety disorders. Women who develop depression or anxiety around childbearing have symptoms that are caused by a combination of psychological, social, and biological stressors. Hormonal fluctuations cause reactions in sensitive women. Risk factors do include a personal or family history of mood or anxiety disorders such as depression, anxiety, bipolar disorder (manic-depressive), and sensitivity to hormonal changes. Developing a perinatal mood and anxiety disorder is not your fault. You did not do anything to “get” this.

Postpartum Support International Website: www.postpartum.net
POSTPARTUM DEPRESSION IS THE MOST COMMON PROBLEM ASSOCIATED WITH CHILDBIRTH

1 in 7 women suffers from postpartum depression (PPD)

Suicide accounts for about 20% of postpartum deaths and is the second most common cause of mortality in postpartum women.

PPD is the most under-diagnosed obstetrical complication in the United States.

Women who have one episode of postpartum depression have 50% chance of experiencing it again with a second pregnancy.

PPD can affect as many as 10% of fathers within the first year.

Within the first 24 HOURS after childbirth, a woman's hormone levels abruptly return to normal. This change may contribute to PPD.

PPD is often treated with counseling and medication.

It may help to talk through your concerns with a mental health professional. Through counseling, you can find better ways to cope with your feelings, solve problems and set realistic goals.

Antidepressants are a proven treatment for postpartum depression. If you're breastfeeding, work with your doctor to weigh the potential risks and benefits of antidepressants, as any medication you take will enter your breast milk.

What is PPD?
PPD is a serious mental health problem characterized by a prolonged period of emotional disturbance, occurring at a time of major life change and increased responsibilities in the care of a newborn infant. PPD can have significant consequences for both the new mother and family.

PPD Symptoms
- Mood changes
- 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
- Withdrawal from family and friends
- Difficulty bonding with your baby
- Thoughts of harming yourself or your baby

What are Baby Blues?
Baby Blues begin in the first few days following delivery and are typically gone by about two weeks postpartum. Symptoms tend to be mild.

Baby Blues Symptoms
- Weepiness/crying for no apparent reason
- Impatience
- Irritability
- Restlessness
- Anxiety
- Sulking
- Mood changes
- Poor concentration

SOURCES:
1. Centers for Disease Control and Prevention, Postpartum Depression.
2. National Institute of Mental Health, Postpartum Depression.
3. American College of Obstetricians and Gynecologists, Postpartum Depression.
4. The World Health Organization, Postpartum Depression.
Lack of Screening and Treatment

Screening and identification of maternal depression and referral for treatment have been minimal at best in the United States. As you saw today in the documentary, “The Dark Side of the Full Moon”, maternal and child outcomes can be dramatically effected by lack of screening, interventions /resources.
Postpartum depression is associated with adverse maternal, infant, and child outcomes, including lower rates of breastfeeding initiation and shorter duration,\(^1\) poor maternal and infant bonding,\(^2\) and infant developmental disorders.
Two Generation Impact
COMMITTEE OPINION

Number 630, May 2015

Committee on Obstetric Practice

This document reflects emerging clinical and scientific advances as of the date issued and is subject to change. The information should not be construed as dictating an exclusive course of treatment or procedure to be followed.

Screening for Perinatal Depression

ABSTRACT: Perinatal depression, which includes major and minor depressive episodes that occur during pregnancy or in the first 12 months after delivery, is one of the most common medical complications during pregnancy and the postpartum period, affecting one in seven women. It is important to identify pregnant and postpartum women with depression because untreated perinatal depression and other mood disorders can have devastating effects on women, infants, and families. Several screening instruments have been validated for use during pregnancy and the postpartum period. Although definitive evidence of benefit is limited, the American College of Obstetricians and Gynecologists recommends that clinicians screen patients at least once during the perinatal period for depression and anxiety symptoms using a standardized, validated tool. Although screening is important for detecting perinatal depression, screening by itself is insufficient to improve clinical outcomes and must be coupled with appropriate follow-up and treatment when indicated; clinical staff in obstetrics and gynecology practices should be prepared to initiate medical therapy, refer patients to appropriate behavioral health specialists, and provide follow-up care for those in need.

(Replaces Committee Opinion Number 453, February 2010, Reaffirmed 2016)
Screening

- ACOG recommends clinicians screen patients at least once during the perinatal period for depression and anxiety symptoms using a standardized, validated tool.
- Clinical staff in OB practices should be prepared to initiate medical therapy, refer patients to appropriate behavioral health resources when indicated, or both.
American Academy of Pediatrics Recommendation for Postpartum Depression Screening
“Given the peak times for postpartum depression specifically, the Edinburgh scale would be appropriately integrated at the 1-, 2-, 4-, and 6-month visits.”
### Recommendations for Preventive Pediatric Health Care

**Bright Futures/American Academy of Pediatrics**

Each child and family is unique; therefore, these recommendations for preventive pediatric health care are designed for the care of children who are rearing competent parenting, to some manifestations of any important health problems, and are growing and developing in a satisfactory fashion, developmentally, psychologically, and health status. Specific disease issues for children and adolescents may require frequent counseling and treatment to separate from preventive care visits. Additional visits may also become necessary if circumstances suggest variations from normal.

These recommendations represent a consensus of the American Academy of Pediatrics (AAP) and Bright Futures. The AAP continues to emphasize the importance of continuity of care and comprehensive health supervision and the need to avoid fragmentation of care. Refer to the specific guidance by age as listed in the Bright Futures Guidelines (Haggard J, Shaw K, Duncombe P, ed. Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents, 4th ed. MMWR, series no. 4, Atlanta, American Academy of Pediatrics, 2017).

The recommendations in this statement do not constitute an exclusive course of treatment or standard of medical care. Variations, taking into account individual circumstances, may be appropriate. Copyright © 2017 by the American Academy of Pediatrics, updated February 2017. No part of this statement may be reproduced in any form or by any means without prior written permission from the American Academy of Pediatrics except for one copy for personal use.

<table>
<thead>
<tr>
<th>Age (Years)</th>
<th>0-1</th>
<th>1-2</th>
<th>2-3</th>
<th>3-4</th>
<th>4-5</th>
<th>5-6</th>
<th>7-10</th>
<th>11-14</th>
<th>15-19</th>
<th>20-21</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Measurement</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Height/Weight</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Head Circumference</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Body Mass Index</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Blood Pressure</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Vision</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Developmental/Physical Health</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Behavior</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Nutrition</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Immunizations</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Counseling/Screening</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Recommendations**

1. **Newborn Well-Baby Visit**
   - Height, weight, and head circumference
   - Cranial nerve reflexes
   - Vitals
   - Immunizations
   - Developmental screening
   - Emotional and behavioral status
   - Nutrition

2. **1-Month Visit**
   - Head circumference
   - Vitals
   - Developmental screening
   - Immunizations
   - Nutrition

3. **2-Month Visit**
   - Developmental screening
   - Immunizations
   - Nutrition

4. **3-Month Visit**
   - Developmental screening
   - Immunizations
   - Nutrition

5. **4-Month Visit**
   - Developmental screening
   - Immunizations
   - Nutrition

6. **5-Month Visit**
   - Developmental screening
   - Immunizations
   - Nutrition

7. **6-Month Visit**
   - Developmental screening
   - Immunizations
   - Nutrition

8. **9-Month Visit**
   - Developmental screening
   - Immunizations
   - Nutrition

9. **12-Month Visit**
   - Developmental screening
   - Immunizations
   - Nutrition

10. **18-Month Visit**
    - Developmental screening
    - Immunizations
    - Nutrition

11. **24-Month Visit**
    - Developmental screening
    - Immunizations
    - Nutrition

<table>
<thead>
<tr>
<th>Age (Years)</th>
<th>0-1</th>
<th>1-2</th>
<th>2-3</th>
<th>3-4</th>
<th>4-5</th>
<th>5-6</th>
<th>7-10</th>
<th>11-14</th>
<th>15-19</th>
<th>20-21</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Recommendations</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**continued...**
Edinburgh Postnatal Depression Scale

- Validated for use during pregnancy and postpartum
- 10 self reported questions about how you have felt in the past 7 days
- Very sensitive for perinatal depression
- Less than 5 minutes to complete
- Low reading level
- Easy to score
- Available in 60 languages
- Score of ≥ 10 is considered positive
- Score does not reflect the severity of the symptoms
The Edinburgh helps identify women with major depression and elevated depressive symptoms.

We need to address elevated depressive symptoms too because they interfere with parenting behaviors and infant development and behavior.

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
   - Hardy ever
   - Yes, sometimes
   - Yes, very often

5. I have felt scared or panic 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
   - Yes, sometimes
   - Not very often
   - No, not at all

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
    - Hardy ever
    - Never

0 to 3 points/item, 10+ is probable Postpartum Depression.

Treatment

- Support Groups
- Talk Therapy/Psychotherapy
- Antidepressants
Resources

Hospital Inpatient:
- OB
- Social Services
- Psychiatry
- Psychology

Hospital Outpatient:
- OB/Pediatrician/PCP
- Social Services
- Healthy Start
Resources

Broward County:

1. Postpartum Support Group at Broward Health Medical Center

2. MOMS (Mothers Overcoming Maternal Stress)
   a. Healthy Mothers, Healthy Babies  954-765-0550  X331
   b. Memorial Healthcare System  gvillalobos@mhs.net

3. Broward Healthy Start Coalition  954-563-7583

4. Pregnancy and Postpartum Group
   Ana Romero  954-558-8360

5. Counseling through insurance plan (if available)
Are you feeling blue or having difficulty coping after giving birth? You are not alone.

POSTPARTUM SUPPORT GROUP

Meetings are held the 2nd and 4th Thursday every month
10:30am - 12pm
Lillian S. Wells Women's Conference Center at Broward Health Medical Center
1600 South Andrews Avenue, Fort Lauderdale, FL 33316

One in seven women may experience symptoms of depression or anxiety during pregnancy and/or up to two years postpartum. Our free support group is designed to provide peer to peer support, emotional support and a safe place to talk about your struggles and anxieties.

- Hosted by trained clinicians
- Complimentary valet
- No fee or reservation required
- Babies welcome
- Light refreshments served

For more information, call Samantha Montealegre, RNC, BSN, IBCLC at 954.468.5276.

Topics include:
- Identifying signs/symptoms of depression/anxiety
- Coping skills
- Healthy communication
- Managing relationships
Resources

**International:**

Postpartum Support International (PSI)
1.800.944.4773
[http://www.postpartum.net/](http://www.postpartum.net/)

Action Postpartum Psychosis  (British Network)
Resources

National:

National Suicide Prevention Lifeline
1-800-273-TALK (8255)  24/7 emergency

www.suicidepreventionlifeline.org
Resources

National:
American College of Obstetricians and Gynecologists
http://www.acog.org/Womens-Health/Depression-and-Postpartum-Depression

National Women’s Health Information Center
http://www.womenshealth.gov/mental-health/illnesses/postpartum-depression.html

Medline Plus
• http://store.samhsa.gov/shin/content/SMA14-4878/SMA14-4878.pdf

• Substance Abuse and Mental Health Services Administration. Depression in Mothers: More Than the Blues—A Toolkit for Family Service Providers. HHS Publication No. (SMA) 14-4878. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014
Broward Health Community Health Services is implementing perinatal depression screening at:

- Cora E. Braynon Family Health Center Prenatal
- Pompano Prenatal Center
- Lauderdale Lakes Health Center Prenatal
- Margate Health Center Prenatal

Broward Health Medical Center has already implemented screening prior to discharge home from the mother-baby unit.
Edinburgh in Prenatal Care

We will be implementing the Edinburgh Postnatal Depression Scale in Prenatal to be completed at the following PNC visits:

- Intake visit
- 28 – 32 week visit
- Postpartum visit
Edinburgh Scale

- Built into EHR
- Will be a Required Task
- Score will determine intervention
  - score of 10 or higher requires physician notification and intervention
  - score higher than zero for question # 10 requires immediate physician notification and intervention
References

- Postpartum Support International  [www.postpartum.net](http://www.postpartum.net)


References


