This toolkit was produced by the Medical College of Wisconsin and is provided to health care providers through The Periscope Project. The goal of this toolkit is to provide practitioners with an up-to-date, reliable, and easy to use source of information for mental health conditions during the perinatal period. The content is based on the latest available evidence-based guidelines and research whenever possible. If you are aware of new guidelines or research, or if you have suggestions that can help improve this toolkit, please contact cwichman@mcw.edu. Please read our disclaimer before using our toolkit.

This toolkit is for educational purposes only and does not constitute medical advice. The toolkit is not a replacement for careful medical judgments by qualified medical personnel. There may be information in the toolkit that does not apply to or may be inappropriate for the medical situation at hand.

Evaluation Guides

- **Evaluating Mood Symptoms** [page 1]
  - *A guide to aid in evaluation of Baby Blues, Perinatal Depression, Bipolar Disorder, Psychosis.*
- **Evaluating Anxiety Symptoms** [page 2]
  - *A guide to aid in evaluation of Perinatal Anxiety, Obsessive Compulsive Disorder, and PTSD.*
- **Clinical Considerations** [page 3]
  - *A general guide to assessing for and discussing psychiatric symptoms with perinatal patients, as well as assessing for imminent risk.*

Screening Tools & Treatment Algorithms

- **The Patient Health Questionnaire 9 (PHQ-9)** [page 4]
  - *A reliable and valid screening tool to assess for both criteria-based depressive symptoms and their severity.*
- **Edinburgh Postnatal Depression Scale (EPDS)** [page 5]
  - *A brief, validated screening tool to assess for depression symptoms in the postpartum period.*
- **Perinatal Anxiety Symptom Screen (PASS)** [page 6]
  - *A brief, validated screening tool to assess for comorbid or independent anxiety symptoms in perinatal women.*
- **Overall Evaluation and Treatment Algorithm** [page 8]
  - *A guide to scoring the PHQ-9, EPDS, and PASS, as well as treatment options for an elevated screening score and/or clinical symptoms.*
- **Antidepressant Treatment Algorithm** [page 9]
  - *A guide to initiating and/or managing treatment of depressive and/or anxiety symptoms with antidepressants, if indicated.*

Informational Materials

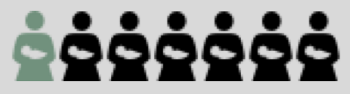
- **PERISCOPE Contact Page** [page 10]
- **Patient Resources** [page 11]

©2017. Medical College of Wisconsin. All rights reserved. May not be used or reproduced without written permission from the Medical College of Wisconsin.

Evaluating Mood Symptoms

Baby Blues	Perinatal Depression	Bipolar Disorder	Psychosis
A common, temporary phenomenon with prominent mood swings in the immediate postpartum period. **An independent risk factor for postpartum depression, especially if symptoms are more severe.* ✦ *Onset*: Typically in the first week following delivery. ✦ *Duration*: No more than 2 weeks. *Signs/Symptoms*: Tearfulness, excessive worrying, mood swings, irritability, difficulties sleeping, changes in appetite. *Treatment*: Will likely resolve naturally without formal intervention. Encourage participation in support groups, asking for help when needed, and healthy self-care practices.	**An episode of major depression occurring in the context of pregnancy and/or the postpartum period.** ✦ *Onset*: During pregnancy, or up to 1 year postpartum. ✦ *Duration*: May persist until treated. *Signs/Symptoms*: Depressed mood, loss of interest in all/most activities, changes in appetite, changes in sleep habits, excessive guilt and/or worry, impaired concentration, recurrent thoughts of death or suicidal ideation. *Treatment*: Therapy, medications. Encourage participation in support groups, asking for help when needed, and healthy self-care practices.	**A mood disorder consisting of both depressive symptoms as well as mania.** ✦ *Onset*: Prior to pregnancy, during pregnancy, or in the postpartum period (often precipitated by disturbed sleep). ✦ *Duration*: Persists until treated. *Signs/Symptoms*: May present with depressive symptoms, as previously delineated. Mania characterized by a decreased need for sleep, risk-taking behaviors (e.g., gambling, promiscuity), euphoria or irritability, increased goal-directed activity, grandiosity. *Treatment*: Medications, therapy. Inpatient hospitalization may be indicated if symptoms are severe and are associated with psychosis. Encourage participation in support groups, asking for help when needed, and healthy self-care practices (most importantly, **sleep hygiene**).	***A psychiatric emergency consisting of notable changes in mental status, typically associated with severe mood symptoms (depression, mania, or a mixed mood episode). Prominent symptoms include delusions, hallucinations, and/or confusion.*** Onset is sudden and deterioration is rapid. Most commonly, onset occurs within 2-12 weeks of delivery, often on days 1-3 postpartum. *Prevalence*: This is a rare complication of pregnancy, occurring in 1-2 women/1,000 births. *Risk Factors*: History of bipolar disorder, a previous episode of psychosis (especially in the postpartum period). *Treatment*: Inpatient hospitalization is usually indicated in these cases.

How *Common* are Mood Symptoms During/After Pregnancy?



1 in 7 women

will be affected by depression in the perinatal period.

- ***50-85%*** will experience symptoms of Baby Blues
- ***2-3%*** will display symptoms of Bipolar Disorder

Who is *at Risk*?

- Personal or family history of a mood disorder
- Lack of social support
- Low socioeconomic status
- History of trauma
- Current domestic violence and/or relationship discord
- Multiple births
- Chronic/medical illness

References:

Howard LM, Molyneaux E, Dennis CL, Rochat T, Stein A, Milgrom J. (2014). Non-psychotic mental disorders in the perinatal period. *Lancet*, 384(9956), 1775-88.

Jones I, Chandra PS, Dazzan P, Howard LM. (2014). Bipolar disorder, affective psychosis, and schizophrenia in pregnancy and the post-partum period. *Lancet*, 384(9956),1789-99.

Yonkers KA, Vigod S, Ross LE. (2011). Diagnosis, pathophysiology, and management of mood disorders in pregnant and postpartum women. *Obstet Gynecol*, 117, 961–77.

©2017. Medical College of Wisconsin. All rights reserved. May not be used or reproduced without written permission from the Medical College of Wisconsin.

Evaluating Anxiety Symptoms

Perinatal Anxiety	Obsessive Compulsive Disorder	PTSD
A spectrum of anxiety symptoms occurring during pregnancy and/or the postpartum period. *Anxiety may occur in conjunction with perinatal depressive symptoms (usually a more severe illness, and more difficult to treat), or independently of mood disturbances.* ✦ *Onset*: If anxiety symptoms present during pregnancy, they most commonly present in the first trimester. If onset is postpartum, symptoms may present in the first 2 weeks to 6 months following delivery. ✦ *Duration*: May persist until treated. *Prevalence*: An estimated 8.5%-13% of women experience an anxiety spectrum disorder in the postpartum period. *Signs/Symptoms*: Persistent and excessive worries (especially about baby's health/safety/well-being), inability to relax, physiological arousal (palpitations/chest pain, air hunger, diaphoresis, dizziness, etc.). *Treatment*: Therapy, medications. Encourage participation in support groups, asking for help when needed, and healthy self-care practices.	**An anxiety spectrum disorder characterized by repeated, intrusive obsessive thoughts that are accompanied by compulsive, sometimes ritualistic behaviors performed to relieve anxiety associated with the intrusive thoughts. Mothers will recognize the thoughts as being irrational and are often fearful of or disturbed by them.** ✦ *Onset*: Prior to pregnancy, during pregnancy, or up to 1 year postpartum. ✦ *Duration*: May persist until treated. *Prevalence*: 4% of women. *Signs/Symptoms*: Disturbing repetitive thoughts that are recognized as irrational (even thoughts of harming the baby); compulsive behaviors often involve behaviors dedicated to protecting the baby (e.g., frequent checking, hand washing, etc.). *Treatment*: Often, a combination of CBT-oriented therapy and medications are more effective than a singular treatment approach. Encourage participation in support groups, asking for help when needed, and healthy self-care practices.	**Anxiety symptoms precipitated by a traumatic experience (including a history of traumatic birth experience). *Preexisting PTSD may also be exacerbated by a traumatic birth experience.*** ✦ *Onset*: May be present prior to pregnancy or result from a traumatic birth experience. ✦ *Duration*: May persist until treated. *Prevalence*: Affects an estimated 2-15% of women. *Signs/Symptoms*: Syndrome that may include nightmares, hyperarousal, pervasive thoughts or re-experiencing of past trauma, irritable mood, the tendency to avoid disturbing stimuli, physiological arousal symptoms. *Treatment*: Therapy, medications. Encourage participation in support groups, asking for help when needed, and healthy self-care practices.

Is It Important to Distinguish Between Perinatal Depression and Perinatal Anxiety?

☛ **Studies have demonstrated that women struggling with perinatal depression will frequently present with significant anxiety symptoms (nearly half of all women experience obsessions and compulsions postpartum–the majority of which do not represent overt OCD, but may signal significant perinatal depression).**

☛ **Detecting comorbid anxiety symptoms will facilitate appropriate and targeted treatment recommendations (SSRIs are effective for both anxiety and depressive symptoms) and confer better outcomes for both mom and baby.**

Who is *at Risk*?

- Personal or family history of an anxiety disorder
- Lack of social support
- Low socioeconomic status
- History of trauma
- Current domestic violence and/or relationship discord
- Multiple births
- Prior pregnancy loss

References:

Miller ES, Hoxha D, Wisner KL, Gossett DR. (2015). The impact of perinatal depression on the evolution of anxiety and obsessive-compulsive symptoms. *Arch Womens Ment Health*, 18(3), 457-61.

Wisner KL, Peindl KS, et al. (1999).Obsessions and compulsions in women with postpartum depression. *J Clin Psychiatry*, 60(3), 176-80.

©2017. Medical College of Wisconsin. All rights reserved. May not be used or reproduced without written permission from the Medical College of Wisconsin.

Clinical Considerations When Assessing the Mental Health of Perinatal Women

Recommended **screening timeline:**

- Initial prenatal visit
- 28 weeks gestation
- 6-week postpartum visit

Utilize a **valid screening tool**.

- Most commonly utilized in pregnancy: EPDS and PHQ-9 *(both included in this toolkit).*
- Acknowledge and thank the mother for completing. Review the score with them. Ask why they chose the answers they did about certain questions.

Have **protocols** in place to address:

- Score above cut-off OR acknowledgement of self-harm (or harm to baby).
- Local mental health resources.
- Emergent resources (if patient is at imminent risk).

Normalize process.

- Acknowledge that you (or your practice) screens all women for mood and anxiety disorders during pregnancy and postpartum periods.

Document as part of OB visit.

How to talk about perinatal depression/anxiety with moms…

- ✦ *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?*

Assessing Suicidal Ideation

Lower Risk	Higher Risk
• No prior attempts • No plan • No intent • No substance use • Protective factors *(what prevents you from acting?)*	• History of suicide attempt(s) • High lethality of previous attempt(s) • Current plan • Current intent • Substance use • Lack of protective factors *(including social support)*

Assessing Thoughts of Harming Baby

Occurring Secondary to Obsessions/Anxiety	Occurring Secondary to Postpartum Psychosis
Good insight Thoughts are intrusive, scary No psychotic symptoms Thoughts cause anxiety	Poor insight Psychotic symptoms Delusional beliefs with distortion of reality present
↓	↓
Suggests not at risk of harming baby	Suggests at risk of harming baby

©2017. Medical College of Wisconsin. All rights reserved. May not be used or reproduced without written permission from the Medical College of Wisconsin.

The Patient Health Questionnaire 9 (PHQ-9)

Patient-administered

Over the **last two weeks,** how often have you been bothered by any of the following symptoms *(circle)*?

Questions	*Not at all*	*Several days*	*More than half the days*	*Nearly every day*
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Trouble falling asleep, staying asleep, or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself– or that you are a failure or have let yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
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
Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

Edinburgh Postnatal Depression Scale (EPDS)

Patient-administered

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.

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, never
   - Hardly ever
   - Yes, sometimes
   - Yes, very often
5) *****I have felt scared or panicky for no 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 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, some of the time
   - 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 happy 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

Adapted from 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.

Perinatal Anxiety Screening Scale (PASS)

Patient-administered

Over the **past month, how often** have you experienced the following symptoms *(circle)*?

	Not at all	*Sometimes*	*Often*	*Almost always*
Worry about the baby/pregnancy	0	1	2	3
Fear that harm will come to the baby	0	1	2	3
A sense of dread that something bad is going to happen	0	1	2	3
Worry about many things	0	1	2	3
Worry about the future	0	1	2	3
Feeling overwhelmed	0	1	2	3
Really strong fears about things (e.g., needles, blood, birth, pain, etc.)	0	1	2	3
Sudden rushes of extreme fear or discomfort	0	1	2	3
Repetitive thoughts that are difficult to stop or control	0	1	2	3
Difficulty sleeping even when I have the chance to sleep	0	1	2	3
Having things to do in a certain way or order	0	1	2	3
Wanting things to be perfect	0	1	2	3
Needing to be in control of things	0	1	2	3
Difficulty stopping checking or doing things over and over	0	1	2	3
Feeling jumpy or easily startled	0	1	2	3
Concerns about repeated thoughts	0	1	2	3
Being “on guard” or needing to watch out for things	0	1	2	3
Upset about repeated memories, dreams, or nightmares	0	1	2	3

PERINATAL ANXIETY SCREENING SCALE (PASS)

Continued from first page…

Over the **past month,** how often have you experienced the following symptoms *(circle)*?

	Not at all	*Sometimes*	*Often*	*Almost always*
Worry that I will embarrass myself in front of others	0	1	2	3
Fear that others will judge me negatively	0	1	2	3
Feeling really uneasy in crowds	0	1	2	3
Avoiding social activities because I might be nervous	0	1	2	3
Avoiding things which concern me	0	1	2	3
Feeling detached like you're watching yourself in a movie	0	1	2	3
Losing track of time and can't remember what happened	0	1	2	3
Difficulty adjusting to recent changes	0	1	2	3
Anxiety getting in the way of being able to do things	0	1	2	3
Racing thoughts making it hard to concentrate	0	1	2	3
Fear of losing control	0	1	2	3
Feeling panicky	0	1	2	3
Feeling agitated	0	1	2	3

Adapted from Sources:

Somerville, S., Dedman, K., Hagan, R., Oxnam, E., Wettinger, M., Byrne, S., Coo, S., Doherty, D., Page, A.C. (2014).

The Perinatal Anxiety Screening Scale: development and preliminary validation. Archives of Women's Mental Health, DOI: 10.1007/s00737-014-0425-8.

© Department of Health, State of Western Australia (2013).

Overall Evaluation and Treatment Algorithm

Complete PHQ-9 or EPDS. Complete PASS if significant anxiety symptoms reported.

- To score PHQ-9:
  - Sum total.
  - Score >10 is considered positive for moderate to severe depression.
- To score EPDS:
  - Questions 1, 2, & 4 (without an *) are scored 0, 1, 2, or 3 (top answer = 0, bottom = 3).
  - Questions 3, 5-10 (with an *) are reverse-scored (top answer = 3, bottom = 0).
  - Score of >10 is considered potentially positive.
- To score PASS:
  - Sum total.
  - Score >26 is considered positive.

Remember that a patient's score may not correlate with symptom severity.

**Discussion points to consider…*

☛**Counsel patient about antidepressant use.**

- No medication is risk-free; SSRIs are the best studied class of antidepressants in pregnancy and lactation.

☛**Data shows that use of antidepressants in pregnancy may increase risk of:**

- Persistent Pulmonary hypertension of the newborn (absolute risk of PPHN is low), pre-term labor, poor neonatal adaptation syndrome (PNAS is typically mild and self-limited).
- Risks are NOT dose-dependent.

☛**Data shows risk of under- or non-treatment of depression in pregnancy may increase risk of:**

- Impaired bonding with baby, poor self-care, postpartum depression (which is associated independently with multiple potential negative outcomes for mother, baby, and family), pre-eclampsia, pre-term labor, substance abuse, suicide.

If score is **high** OR patient is clinically **symptomatic**:

→ Ask: *"Have you ever had periods of at least three days straight of feeling so happy or energetic that your friends told you you were talking too fast or that you were "too hyper?""*[1]

→ If "***NO***," then *discuss options for treatment of unipolar depressive and/or anxiety symptoms.

→ Watchful waiting with increased self care.

→ Psychotherapy *(either stand-alone, if clinically appropriate, or adjunctive treatment).*

→ Antidepressant Therapy *(see antidepressant treatment algorithm if the patient agrees to this option).*

→ If "***YES***," then consult PERISCOPE. Patient should be more thoroughly screened for Bipolar Disorder before any treatment is initiated.

If score is **low** AND patient is clinically **asymptomatic**:

→ Continue to screen using PHQ-9 or EPDS at subsequent perinatal visits.

[1]Adapted from Daniel J. Carlat. (1998) *Am Fam Physician*, 58(7), 1617-1624.

©2017. Medical College of Wisconsin. All rights reserved. May not be used or reproduced without written permission from the Medical College of Wisconsin.

Antidepressant Treatment Algorithm

Complete **Depression Screen** (PHQ-9 or EPDS) **+/- PASS**, and ask **single Bipolar Screen question.**

- *Does patient **screen positive for depression** and **negative for mania**?*
- *Is patient currently taking an antidepressant?*

If "yes" to both:

- If medication is still low dose, increase and optimize both.
- If dose has been therapeutic for 6-8 weeks without benefit, consider changing medication.

If "no" to second:

- If patient was formerly on a helpful medication, **re-start** with slow titration.
- Start with an agent below, depending upon side effect profile.

Sertraline

- Start at 50 mg daily.
- Increase in 50 mg increments every 1-2 weeks, maximum dose of 200 mg daily.
- Few drug-drug interactions.
- May increase nausea/GI upset, but generally well tolerated.

Fluoxetine

- Start at 20 mg daily.
- Increase in 10-20 mg increments every 1-2 weeks, maximum dose 80 mg.
- Long half-life, so good choice if compliance is a concern.

Citalopram

- Start at 20 mg daily.
- Can double dose in 1-2 weeks, maximum dose of 40 mg daily.
- Generally well tolerated.
- Short titration, as low max dose.

Duloxetine

- Start at 30 mg daily.
- Increase in 30 mg increments every 1-2 weeks (rate of titration should depend upon GI side effects), maximum dose of 120 mg daily.
- Typically BID dosing; if sedating, give higher dose at night.
- Good choice if co-morbid pain complaints.

Mirtazapine

- Start at 15 mg nightly.
- Increase in 15 mg increments every 1-2 weeks, maximum dose of 45 mg daily.
- Good if patient has significant nausea, low appetite, or difficulty sleeping.
- MONITOR WEIGHT GAIN; discontinue if rate of weight gain is too rapid.

Re-evaluate after 4-6 weeks. *If improved*:

- Re-evaluate monthly and postpartum.
- Refer back to primary provider when obstetric care complete.
- Continue to offer non-medication based therapies.
- Call PERISCOPE if arranging follow-up is difficult or any questions arise.

Re-evaluate after 4-6 weeks. If *not improved*, or having side effects:

- If minimal side effects, increase dose and repeat cycle until maximum dose achieved.
- If intolerable side effects, switch to different medication and repeat cycle.

©2017. Medical College of Wisconsin. All rights reserved. May not be used or reproduced without written permission from the Medical College of Wisconsin.

Contact Us

☎ 1.877.296.9049

✉ theperiscopeproject@mcw.edu

Monday-Friday, 8:00 AM- 4:00 PM (excluding holidays).

Your call will be answered by a triage staff member.

©2017. Medical College of Wisconsin. All rights reserved. May not be used or reproduced without written permission from the Medical College of Wisconsin.

Patient Resource Guide

If questions persist after your clinic visit, we recommend against searching for answers on the internet. Below is a list of websites that publish evidence-based information on the topic of women's mental health during pregnancy and the postpartum period.

- HTTPS://WOMENSMENTALHEALTH.ORG/
  - **The Massachusetts General Hospital (MGH) Center for Women's Mental Health**: *"This internet-based resource was designed in an effort to provide scientifically sound and clinically useful information to caregivers and patients at a time when the field of women's mental health is quickly evolving. One of the primary goals of the Center is to empower patients with information to make informed decisions about their care."*
  - Website includes topic-focused information, a library section featuring latest research, and a frequently updated blog.
- HTTPS://WWW.NICHD.NIH.GOV/NCMHEP/INITIATIVES/MOMS-MENTAL-HEALTH-MATTERS/
  - **Moms' Mental Health Matters**: *"The Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD), part of the National Institutes of Health (NIH), has launched Moms' Mental Health Matters, a new initiative to raise awareness among pregnant and postpartum mothers, their families, and health care providers about depression and anxiety during pregnancy and after the baby is born. Free materials available in both English and Spanish."*
- HTTP://WWW.POSTPARTUM.NET/
  - **Postpartum Support International**: *"PSI disseminates information and resources through its volunteer coordinators, website and annual conference. Its goal is to provide current information, resources, education, and to advocate for further research and legislation to support perinatal mental health."*
  - Website includes information on pregnancy and postpartum mental health symptoms, a local support/resource map, as well as information as to intensive perinatal psychiatric treatment (inpatient and outpatient) available across the country.

©2017. Medical College of Wisconsin. All rights reserved. May not be used or reproduced without written permission from the Medical College of Wisconsin.