

Pregnancy Related Depression & Anxiety and Mood Disorders

Healthcare Provider Toolkit



Larimer County
Pregnancy Related
Depression & Anxiety
and Mood Disorders Coalition



Provided courtesy of Larimer County Department of Health & Environment's Pregnancy Related Depression & Anxiety and Mood Disorders Coalition, with inputs from Colorado Department of Public Health & Environment, and Postpartum Support International.

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PREGNANCY RELATED DEPRESSION (PRD) AND ANXIETY/MOOD DISORDERS COALITION

The Pregnancy Related Depression & Anxiety and Mood Disorders Coalition (PRD/AMD) was initiated in 2014 by the Larimer County Department of Health and Environment, through the Maternal Child Health (MCH) block grant priority area of *Women's Mental Health: Pregnancy Related Depression*. Our goal is to reduce stigma associated with maternal mental health and to increase the number of women identified with PRD who seek treatment.

The PRD/AMD Coalition is made up of health and human service-related representatives who seek to support women, families, and health care providers in achieving healthy pregnancies and improved birth outcomes in Larimer County. As a coalition, we strive to ensure that optimal care and services are provided to women in the prenatal and postpartum period as well as their infants, children, and families. We accomplish this through identifying gaps, barriers, strengths, and weaknesses of those living with pregnancy-related depression and/or mood disorder(s).

If you are interested in more information about the PRD/AMD Coalition of Larimer County or would like to participate, please contact: Andrea Clement-Johnson, MS, Health Promotion and Community Intervention Manager at: aclement-johnson@larimer.org

WHAT IS PREGNANCY RELATED DEPRESSION AND ANXIETY & MOOD DISORDERS?

Pregnancy-related mood and anxiety disorders occur during pregnancy, after giving birth, following adoption, and after a pregnancy loss. In Colorado, nearly 1 in 9 women who give birth will experience signs and symptoms of depression and/or anxiety. This makes pregnancy-related mood disorders the most common complication of pregnancy (PSI, 2018).

According to Postpartum Support International (PSI), 10% of women experience depression in pregnancy and approximately 15% of women experience significant depression following childbirth; the percentages are higher for women living in poverty and can be twice as high for teen parents. Symptoms of pregnancy-related depression can start anytime during pregnancy or the first year postpartum. They may include the following: feelings of anger or irritability, lack of interest in the baby, appetite and sleep disturbance, crying and sadness, feelings of guilt, shame or hopelessness, loss of interest, joy, or pleasure in things previously enjoyed, and possible thoughts of harming the baby or oneself (PSI, 2018). Women with pregnancy-related depression are less likely to report feelings of sadness than other persons with depression; rather, they commonly have prominent feelings of guilt or worthlessness, and experience a loss of enjoyment of usually pleasurable activities (Hirst & Moutier, 2010).



Perinatal Generalized Anxiety Disorder (GAD) has a high prevalence of 8.5%–10.5% during pregnancy and 4.4%–10.8% postpartum. GAD is characterized by excessive, uncontrollable worry that can cause functional impairment. These worries become disabling if they are recurrent, time-consuming, intrusive, and acquire a quality of irrationality. If these worrisome symptoms persist for an extended period, they can cause functional impairment in every area of the mother's life (Misri et al.,

2015). Additional symptoms of perinatal anxiety include constant worry, feeling that something bad is going to happen, racing thoughts, disturbances of sleep and appetite, inability to sit still, physical symptoms like dizziness, hot flashes, and nausea (PSI, 2018).

IDENTIFYING RISK FACTORS FOR PRD/AMD

The single greatest risk factor for pregnancy-related depression is a prior history of depression (Langan & Goodbred, 2016). Women with a history of anxiety or mood disorder symptoms during the pregnancy or those who have an episode of the "baby blues" following delivery are at increased risk of a major depressive episode in the pregnancy-related period (APA, 2013). Other risk factors include, but are not limited to, the following list (ACOG, 2015; ACOG, 2016; Langan & Goodbred, 2016; Norhayati, et al., 2015, PSI, 2017):

- A history of trauma and/or abuse
- Personal or family history of anxiety or previous perinatal depression or anxiety
- Lack of social support and single parent status
- Low socio-economic status or educational level
- Unintended pregnancy or a negative attitude toward the pregnancy
- Traumatic childbirth experience, neonatal intensive care unit admission or infant medical illness
- Stress related to child care issues and intention to return to work
- Perceived stress, difficulties with breastfeeding, or a temperamentally difficult infant
- Surrogate pregnancy/adoption or teen pregnancy
- Sleep deprivation
- Miscarriage or infant loss

*It is important to note, however, that a woman without any known risk factors may also develop pregnancy-related depression.

CONCERNS OF UNTREATED PRD/AMD

Untreated PRD interferes with a mother's ability to engage in positive interactions with her child. The lack of positive interactions with the mother increases the child's risk of developing insecure attachments, problematic behavior, and psychopathology while also decreasing the child's cognitive and social competency.

Studies have found that recurrent negative thinking in mothers with GAD resulted in mothers being less responsive and engaged in interactions with their infants. In addition, these infants appeared to be withdrawn and were more likely to display lowered emotional tone. 75% of postpartum women with GAD also met criteria for depression (Misri et al., 2015). Given the risks associated with PRD/AMD on the parent-child relationship, it is important to refer families to infant mental health professionals who can address disruptions to the relationship.



Infant Mental Health Resources:

<http://coaimh.org/resources/>

SCREENING FOR PRD/AMD

PRD is a common, potentially serious, and sometimes life-threatening condition. All mothers should undergo screening for depression at the pregnancy-related visit. It is important to note that because common symptoms of depression overlap considerably with those of normal pregnancy and pregnancy-related periods (e.g., changes in appetite, sleep patterns, and libido), perinatal depression often goes unrecognized. For those who initially screen negative for PRD, repeat screening should be considered at a later visit or when the mother takes her baby in for a checkup.

A standardized self-administered screening tool, followed by a review of the patient's responses and follow-up questions in a face-to-face interview with the provider, will ensure consistency and efficiency in the screening process (ACOG, 2015; Myers, et al., 2013; Langan & Goodbred, 2016; Norhayati, et al., 2015; O'Connor, et al., 2016; O'Hara & Scott). Care teams should include collaboration between the obstetrician, family practice physician, and pediatrician as well as any outside referral such as mental health provider(s).

The primary care pediatrician plays a key role in identifying maternal depression through the supportive long-term family relationship that can benefit the development and mental health outcomes for the infant and family (Earls, M. F., 2010). Baby checkup visits also offer a good opportunity to screen mothers who missed their pregnancy-related visit, those who might benefit from repeat screening, and those who failed to undergo earlier screening for any reason (Earls & American Academy of Pediatrics [APA] Committee on Psychosocial Aspects of Child and Family Health, 2010).

The PRD/AMD Coalition recommends the following screening schedule:

- 1st prenatal visit and at least once in 2nd and 3rd trimester, and
- 6-week postpartum obstetrical visit (or at first postpartum visit), and
- Repeated screening at 6 and/or 12 months in OB and primary care settings, and
- 2, 4, 6, and 12-month pediatric visits

<http://www.postpartum.net/learn-more/screening/>

SCREENING METHODS

To help mothers receive screening without undue interruption of a clinic workflow, the following methods could be used as a convenient approach to screening:

- Give each pregnancy-related woman a screening tool to complete, in the form of a printed sheet with a clipboard, while she waits for her visit with the clinician.
- Score the completed tool according to the standards provided for each tool and assess whether the screen is positive or negative (O'Hara & Scott).
- Tools can be scored by a nonclinical staff person.
- A clinician with appropriate training should review the screen, discuss it with the woman, and ask follow-up questions to evaluate her risk of having pregnancy-related depression.

SCREENING AND DIAGNOSTIC TOOLS

The following pregnancy-related depression screening tools have been validated for use in pregnancy-related patients:

EDINBURGH POSTNATAL DEPRESSION SCALE (EPDS; COX, ET AL., 1987)

Edinburgh Postnatal Depression Scale (EPDS; Cox, et al., 1987)

The EPDS can be used during pregnancy and in the postpartum period, specifically within the first year. The Edinburgh Postnatal Depression Scale (EPDS) is the most well-known, validated instrument for screening pregnancy-related depression. It has 10 questions, is free, is relatively easy to score, and can be completed in less than 5 minutes by the mother. Tool guidelines indicate that a score of greater than 10 is a positive screen and that a mother needs additional behavioral health follow-up care. In addition, the EPDS scale was found useful in identifying symptoms of anxiety (Brouwers, E.P., Van Baar, A.L., and Pop, V.J., 2001). The EPDS is a reliable and valid measure found in fathers as well as mothers and should be considered for both parents (Loscalzo, Y., Giannini, M., Contena, B., et. al., 2015). The EPDS has been studied in various cultural groups and translated into multiple languages, making it applicable for a wide range of populations.

- Edinburgh Postnatal Depression Scale (EPDS) in English
 - <http://cchap.org/wp-content/uploads/2015/02/Edinburgh-English.pdf>
- Edinburgh Postnatal Depression Scale (EPDS) in Spanish
 - <http://cchap.org/wp-content/uploads/2015/02/Edinburgh-Spanish.pdf>
- Instructions for using the EPDS
 - <http://cchap.org/wp-content/uploads/2015/02/Instructions for using EPDS.pdf>

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9; YAWN, ET AL., 2009)

The PHQ-9 is a nine-item depression scale. It is one of the most validated tools in mental health and can be a powerful tool to assist clinicians with diagnosing depression and monitoring treatment response. The nine items of the PHQ-9 are based directly on the nine diagnostic criteria for major depressive disorder in the DSM-IV. The PHQ-9 is rather unique in that it functions as a screening tool, an aid in diagnosis, and as a symptom tracking tool that can help track a patient's overall depression severity as well as the improvement of specific symptoms following treatment.

PHQ-9 in English

<http://www.coloradohealthpartnerships.com/provider/integrated/PHQ9-English.pdf>

PHQ-9 in Spanish

<http://www.coloradohealthpartnerships.com/provider/integrated/PHQ-9-Spanish.pdf>

The EPDS or PHQ-9 recommended cut-off score for a positive screening is 10. The EPDS is a reliable and valid measure of mood in fathers.

Pregnancy-Related Depression and Anxiety Symptoms Guidance Algorithm

https://www.colorado.gov/pacific/sites/default/files/HTW_PRD_Pregnancy-Related-Depression-Guideline_March-2017.pdf

MOOD DISORDER QUESTIONNAIRE

It is helpful to provide a Mood Disorder Questionnaire (MDQ) with the EPDS when determining unipolar vs. bipolar disorders. Providers should inquire about any history of bipolar disorder or manic symptoms, as women with bipolar disorder are at increased risk of pregnancy-related depression. For any woman with suspected manic symptoms or bipolar disorder, or any history of a psychotic disorder, referral to a mental health professional for evaluation and treatment should be considered, since the management of these conditions may be complex (Hirst & Moutier, 2010; Langan & Goodbred, 2016).

MDQ: <http://www.sadag.org/images/pdf/mdq.pdf>

*****Any patient with a positive response to questions related to suicide risk on the screening tool, and any patient who expresses or is suspected of having suicidal thoughts or ideas, should immediately undergo a thorough suicide risk assessment and possible hospitalization. (Zero Suicide Advisory Group, 2015). If you are needing assistance with a patient in CRISIS, call SummitStone 24-hour Crisis Line (970) 494-4200 x1.**

POSTPARTUM PSYCHOSIS

Although pregnancy-related psychosis is uncommon, approximately one-half of such episodes represent the initial manifestation of a severe psychiatric disorder. Any woman with psychotic symptoms at the time of evaluation or in the recent past (either self-reported or observed by another person) should be referred for emergent psychiatric evaluation and consideration of hospitalization, as her condition may deteriorate very rapidly (Langan & Goodbred, 2016; Meltzer-Brody & Jones, 2015).



Postpartum psychosis is a rare illness compared to the rates of postpartum depression or anxiety. The onset is usually sudden, most often within the first 2 weeks postpartum. Of the women who develop a postpartum psychosis, research has suggested that there is approximately a 5% suicide rate and a 4% infanticide rate associated with the illness. Immediate treatment for a woman going through psychosis is imperative.

It is also important to know that many survivors of postpartum psychosis never had delusions containing violent commands. Delusions take many forms, and not all of them are destructive. Most women who experience postpartum psychosis do not harm themselves or anyone else. However, there is always the risk of danger because psychosis includes delusional thinking and irrational judgment, and therefore women with this illness must be quickly assessed, treated, and carefully monitored by a trained perinatal mental health professional.

SYMPTOMS OF POSTPARTUM PSYCHOSIS:

- Delusions or strange beliefs
- Hallucinations (seeing or hearing things that aren't there)
- Feeling very irritated
- Hyperactivity
- Decreased need for or inability to sleep
- Paranoia and suspiciousness
- Rapid mood swings
- Difficulty communicating at times

SCREENING FOR POSTPARTUM PSYCHOSIS

A woman with known bipolar disorder and a personal or family history of postpartum psychosis is at substantial risk. She and her family should be informed of the symptoms to recognize including: mood swings, confusion, strange beliefs, and hallucinations. Contacting her physician if these symptoms arise is essential. Even before delivery, the at-risk patient is encouraged to consult with a psychiatrist to help her consider treatment options or treatment prophylaxis at delivery to avoid illness.

Physicians are strongly urged to ask about symptoms of postpartum psychosis in the high-risk patient at her 6-week obstetrical follow-up visit. The Edinburgh Postnatal Depression Scale (EPDS) and the Mood Disorder Questionnaire (MDQ) are useful tools to screen for depression and mania/hypomania. When the patient reports confusion, threats to harm herself or others, is having difficulty caring for her children, or is exhibiting poor self-care, a psychiatric referral must be arranged immediately.

Postpartum Psychosis Resources

<http://www.postpartum.net/learn-more/postpartum-psychosis/>

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3109493/pdf/nihms294422.pdf>

TREATMENT OF PREGNANCY RELATED DEPRESSION AND ANXIETY: INTEGRATED MODEL OF SUPPORT

Ideally, a team approach should be taken when treating women with PRD, which includes: healthcare and mental health providers, pharmacists, psychological services, and social support networks.

NONPHARMACOLOGIC TREATMENT

Cognitive-behavioral therapies are the first-line choice for the treatment of mild to moderate pregnancy-related depression and perinatal GAD. However, in moderate to severe cases, pharmacological treatment should be considered (Misri et al, 2015).

Treatment of mild-to-moderate pregnancy related depression and anxiety may include psychological and behavioral therapies, such as individual or group counseling, interpersonal psychotherapy (IPT), and partner-assisted IPT (Hirst & Moutier, 2010; Langan & Goodbred, 2016; Meltzer-Brody & Jones, 2015).

Social and partner support during the perinatal period can buffer the effects of PRD/AMD. It can improve physical and psychological well-being and decrease parenting stress. Types of social support include emotional, practical, informational and peer.

PHARMACOLOGIC TREATMENT

For patients with more severe symptoms and those who do not respond to non-pharmacologic therapy, medication therapy may be appropriate. Selective serotonin reuptake inhibitors (SSRIs) are one class of drugs commonly used to treat pregnancy-related depression (Hirst & Moutier, 2010, Langan & Goodbred, 2016). There is no evidence that one agent is superior to any other. If the patient has taken an antidepressant in the past with good result, that agent would be a logical choice to initiate therapy in the absence of contraindications.

Pregnancy-Related Depression & Anxiety Symptoms Guidance

https://www.colorado.gov/pacific/sites/default/files/HTW_PRD_Pregnancy-Related-Depression-Guideline_March-2017.pdf

Medication Algorithm

https://www.colorado.gov/pacific/sites/default/files/HTW_PRD_Medication-Algorithm.pdf

Breastfeeding

Pregnancy-related depression and treatment with antidepressant medications are not contraindications for breastfeeding. Women who wish to breastfeed while taking antidepressants should be counseled on the benefits of breastfeeding, the value of treating pregnancy-related depression (including the risk of untreated depression), the potential risk of exposure of the infant to the medication or its metabolites, and the limitations of evidence related to the effects on the infant (Sachs & APA Committee on Drugs, 2013). Those who choose to breastfeed should receive encouragement and support to overcome challenges and obstacles that may be present (Sriraman, et al., 2015), and providers should consider monitoring the growth and neurodevelopment of the infant (Sachs & APA Committee on Drugs, 2013).

Helpful Lactation & Medication Resources

<https://www.infantrisk.com/>

<http://www.motherisk.org/>

BILLING AND REFERRAL TO TREATMENT

A pediatric primary care provider who sees an infant for a well-baby visit may now bill for postpartum depression screening on the mother using the Medicaid ID of the infant (effective August 1, 2014). Maternal depression screenings are considered a “risk assessment” for the child, and screenings must be done with approved standardized screening tools. The procedure code for postpartum depression screening is G8431 for a positive screen, and G8510 for a negative screen (Medicaid claims only). It is important to use an appropriate diagnosis code. For CHP+ and commercial plans, bill using CPT 99420.

Acceptable screening tools include the Edinburgh Postnatal Depression Scale and the PHQ-9. Postpartum depression screening counts as an annual depression screen.

[Click here for the Medicaid Depression Screening Toolkit](#)

<http://cchap.org/wp-content/uploads/2015/03/DepressionScreeningToolkit2015.pdf>

Many of the largest commercial health plans also reimburse for this screening.

Additional information may be found on the Medicaid website: colorado.gov/hcpf.

If a behavioral health need is identified after screening, the pediatric provider should assist with referring the mother to a Behavioral Health Organization (BHO).

MENTAL HEALTH REFERRAL RECOMMENDATION

Connections:

Offers answers, options, support and referral for mental health issues. Providers can refer patients to Connections, **Connections will refer patients to the appropriate mental health provider**. Connections can send updates back to the referring Provider.

P: (970) 221-5551

A: 525 W Oak St, Fort Collins

CAYAC through Connections:

CAYAC (Child, Adolescent and Young Adult Connections) Services are open to all Larimer County youth up to age 24, as well as their families. Others who work with youth (teachers, coaches, daycare providers) can call Connections for information, assistance, resources and guidance to support their work with youth and families.

SummitStone: Walk-In Crisis Center, a Partnership with Colorado Crisis Services

This center offers 24/7/365 care to people of all ages in behavioral health crisis.

Crisis Stabilization Unit: This licensed, 24/7/365 facility combines walk-in availability and crisis beds for up to five days if needed (ages 18 and over).

Mobile Crisis Response: Mobile crisis counselors are available to travel throughout Larimer County to community settings.

P: (970) 494-4200

A: 1217 Riverside Ave., Fort Collins

<http://coloradocrisisservices.org>

RESOURCES FOR SUCCESS

FOR PROVIDERS

[Postpartum Support International](#): In addition to providing information and resources for families and communities, PSI also offers weekly support calls staffed by behavioral health professionals on Wednesdays for mothers and Mondays for fathers.

[Postpartum Support International – Colorado Chapters](#): PSI has five local coordinators that can help practices or families locate community resources and support groups. Lia Closson Postpartum Support International (PSI) Colorado Co-Coordinator. (970) 581-9204

[Motherisk.org](#): Provides a wide-range of resources on various pregnancy related topics, including mood disorders and illicit drug use during pregnancy. Trained counselors are available

by phone (for families and providers) Monday through Friday 9 AM to 5 PM EST for support and guidance. 1 (877) 439-2744

[Infant Risk Center \(Texas Tech University\)](#): An empirical resource that provides up-to-date clinical information about a wide-range of topics related to pregnancy, including depression, substance use, and use of prescribed medications. Healthcare providers and families are encouraged to call Monday through Friday 8 AM to 5 PM Central time. 1 (806) 352-2519

[The Colorado Department of Public Health and Environment \(CDPHE\)](#): provides information on pregnancy-related depression and resources for families and healthcare providers in Colorado. <https://www.colorado.gov/pacific/cdphe/pregnancy-related-depression>

[Rocky Mountain Crisis Partners \(formerly Metro Crisis Services\)](#): Emergency Mental Health and Substance Abuse Services for Colorado. Open to families from any county, any time – hotline is open 24/7. 1 (888) 885-1222. Providers are welcome to call and ask questions about how to manage a psychiatric crisis. Cards, brochures, and promotional materials are available upon request.

CLIENT MATERIALS

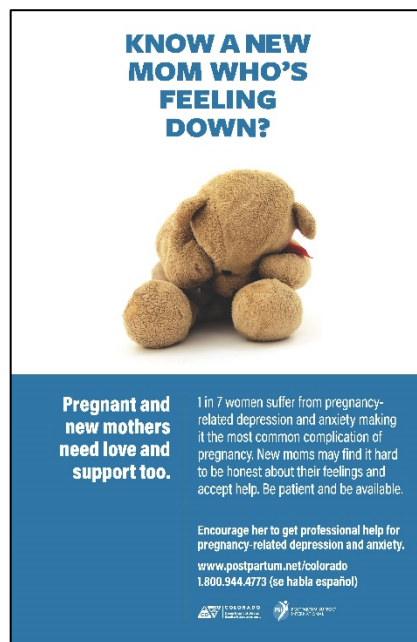
Samples of Pregnancy-Related Depression & Anxiety Public Awareness Campaign

All Materials Available for Free Download:

<https://www.colorado.gov/pacific/cdphe/prd-public-awareness-campaign>

Posters – Available in English and Spanish

- **Poster- 11 x 17 Let's Talk About the Elephant in the Room**
 - [11X17 SUPPORT PRINT ELEPHANT.pdf](#)
- **Poster- 11 x 17 Know a New Mom Who's Feeling Down?**
 - [11X17 SUPPORT PRINT BEAR.pdf](#)



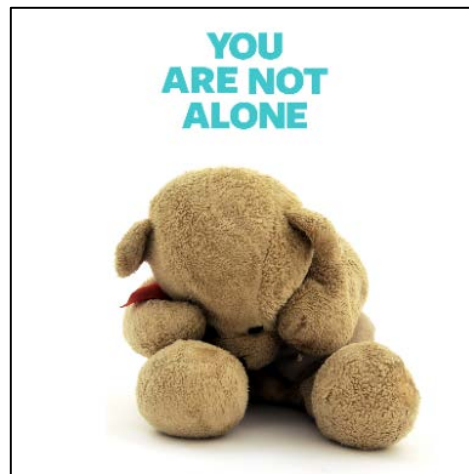
Flyers- For pregnant and new mothers- Available in English and Spanish

- **4UP Flyer You Are Not Alone**
 - [4UP FLYER MOM PRINT BEAR.pdf](#)
- **4UP Flyer Don't keep Your Feelings Bottled Up**
 - [4UP FLYER MOM PRINT BOTTLE.pdf](#)
- **4UP Flyer Let's Talk About the Elephant in the Room**
 - [4UP FLYER MOM PRINT ELEPHANT.pdf](#)

<p>DON'T KEEP YOUR FEELINGS BOTTLED UP</p>  <p>Having a baby wasn't supposed to feel like this</p> <p><i>Overwhelmed? Scared? Hopeless?</i> For women with pregnancy-related depression and anxiety, each day can be a struggle. It's okay to ask for help.</p> <p>YOU ARE NOT ALONE. YOU ARE NOT TO BLAME. THERE IS HELP.</p> <p>www.postpartum.net/cotacambio 1.800.944.4773 (En habla española)</p> 	<p>DON'T KEEP YOUR FEELINGS BOTTLED UP</p>  <p>Having a baby wasn't supposed to feel like this</p> <p><i>Overwhelmed? Scared? Hopeless?</i> For women with pregnancy-related depression and anxiety, each day can be a struggle. It's okay to ask for help.</p> <p>YOU ARE NOT ALONE. YOU ARE NOT TO BLAME. THERE IS HELP.</p> <p>www.postpartum.net/cotacambio 1.800.944.4773 (En habla española)</p> 
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 <p>CUIDAR A TU BEBÉ ES UN TRABAJO INTENSO PARA HACERLO SOLA.</p> <p>Tener un ambiente seguro para hablar sobre tus preocupaciones puede ayudarte a ser una mejor mamá. Está bien hablar sobre tus sentimientos y pedir ayuda.</p> <p>Estamos para apoyarte a que te expreses libremente y sin sentirte juzgada.</p> <p>Para recibir ayuda gratis inmediatamente y de manera confidencial, visita postpartum.net/ayuda o lléname al 1.800.944.4773 (En habla española).</p> 	 <p>CUIDAR A TU BEBÉ ES UN TRABAJO INTENSO PARA HACERLO SOLA.</p> <p>Tener un ambiente seguro para hablar sobre tus preocupaciones puede ayudarte a ser una mejor mamá. Está bien hablar sobre tus sentimientos y pedir ayuda.</p> <p>Estamos para apoyarte a que te expreses libremente y sin sentirte juzgada.</p> <p>Para recibir ayuda gratis inmediatamente y de manera confidencial, visita postpartum.net/ayuda o lléname al 1.800.944.4773 (En habla española).</p> 
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Social Media Images and Content



Spanish Language Materials



NO LA DEJES SOLA, AYÚDALA CON EL TRABAJO INTENSO DE CUIDAR AL BEBÉ.

Ayuda a una mamá hablando con ella sobre cómo se siente y ofreciéndole ayuda con el cuidado del bebé mientras ella descansa. Ayúdala preparando comida para la familia.

Ten paciencia y disponibilidad.

Para recibir ayuda gratis inmediatamente y de manera confidencial, visita postpartum.net/ayuda o llame al 1.800.944.4773 (Se habla español).




TENER QUIEN LA ESCUCHE Y RECIBIR APOYO PUEDE AYUDAR A UNA MAMÁ A SENTIRSE MEJOR.

A las mamás les puede ser difícil ser honestas sobre lo que sienten. Ayúdala a crear un lugar seguro para compartir sus sentimientos y recibir ayuda.

Ten paciencia y disponibilidad.

Para recibir ayuda gratis inmediatamente y de manera confidencial, visita postpartum.net/ayuda o llame al 1.800.944.4773 (Se habla español).




CUIDAR A TU BEBÉ ES UN TRABAJO INTENSO PARA HACERLO SOLA.

Sentirte agobiada cuidando de tu familia es algo que no tienes que hacer sola. La siguiente información te va a ayudar a entender mejor cómo te sientes y a aprender maneras de obtener ayuda para ti y tu familia.

Tener un bebé es difícil. Podemos ayudarte a que sea más fácil.

Para recibir ayuda gratis inmediatamente y de manera confidencial, visita postpartum.net/ayuda o llame al 1.800.944.4773 (Se habla español).



INFORMACIÓN PARA LAS MAMÁS

¿Qué son estos sentimientos y qué los causan con?
Sentimientos de ansiedad, ansiedad y agotamiento pueden presentarse durante el embarazo o después del nacimiento del bebé, incluso después de una pérdida de embarazo. Los llamamos depresión y ansiedad relacionadas con el embarazo, pero no todas las mujeres. De hecho, una de cada siete mujeres sufre de depresión y ansiedad relacionadas con el embarazo convirtiéndose en una de las complicaciones más comunes del embarazo.

¿A quién afecta?
Padres y madres de cualquier cultura, edad, nivel de ingresos y raza pueden sufrir de depresión y ansiedad relacionadas con el embarazo. Las mujeres son afectadas con más frecuencia, pero también puede afectar a los padres, papás y familiares cercanos.

¿Cuáles son los síntomas?
Los síntomas pueden presentarse en cualquier momento durante el embarazo o hasta el primer año del bebé. Los síntomas varían entre las personas y pueden incluir:

- Sentimientos de aislamiento y preocupación.
- Ansiedad constante.
- Falta de interés en el bebé.
- Pérdida del apetito y dificultad para dormir.
- Sentimientos de culpa, vergüenza o falta de esperanza.
- Pérdida de interés, alegría o placer en las cosas que antes disfrutabas.
- Sentimientos de angustia o irritabilidad.
- Posibles pensamientos de hacer daño al bebé o a ti misma.

¿Cuál es la causa?
No hay una sola causa de la depresión y ansiedad relacionadas con el embarazo. Pensamos con antecedentes personales o familiares de trastornos emocionales o de ansiedad como depresión, ansiedad, trastorno bipolar (maníaco-depresivo) y esquizofrenia. Los cambios hormonales tienen más probabilidad de estar en riesgo de tenerlos. Recuerda, tener depresión y ansiedad relacionadas con el embarazo no es tu culpa y hay ayuda disponible para ti.

¿Qué pasa si no se trata?
Sin un tratamiento y la ayuda adecuada, la depresión y ansiedad relacionadas con el embarazo pueden tener un efecto dañino en tu bienestar y en la salud de tu familia. Los bebés necesitan y quieren estar cerca de sus mamás. Algunas mamás con depresión y ansiedad relacionadas con el embarazo tienen dificultad para estar cerca de sus bebés. Esto afecta el desarrollo del bebé. Las mamás pueden estar más conectadas con sus bebés al recibir tratamiento y participar en programas que los ayude con la crianza. Debido a esto, es importante que le ayudes a que busque ayuda.

¿Se puede tratar?
Sí. La depresión y ansiedad relacionadas con el embarazo no se pueden resolver de un día para otro, pero pueden ser tratadas. Los planes de tratamiento son diferentes para cada mujer, pero pueden incluir un aumento en el cuidado prenatal, grupo de apoyo, terapia o medicamentos y tratamiento de los síntomas con medicamentos de ser necesario. Encuentra lo que funciona mejor.

¿Qué puedo hacer?
Cuidar de tu familia significa también cuidar de ti misma. Encuentra tiempo para ti misma cuando puedas. Hay muchas cosas que puedes hacer para ayudarte en tu bienestar, incluyendo pedir ayuda de aquellos a tu alrededor:

- Pide ayuda de tu pareja, familia y amigos de modo que puedas comer alimentos saludables, mantenerte activa, descansar lo suficiente y tener tiempo para ti.
- Únete a un grupo de apoyo de otras mamás en tu área o en línea.
- Habla con tu proveedor.
- Pide ayuda cuando la necesites.
- Aprende más sobre la depresión y ansiedad relacionadas con el embarazo.
- No te rindas! Te puede tomar más de un intento para obtener la ayuda adecuada que necesitas.

¿Qué puedo hacer?
Está bien hablar sobre tus sentimientos y pedir ayuda. No es tu culpa y sentirte así no te hace una mala mamá. Tener un embarazo seguro para hablar sobre tus preocupaciones puede ayudarte a ser una mejor mamá. Los recursos a continuación están disponibles para tu ayuda, para que te expreses libremente y sin sentirte juzgado.

Recursos:

- postpartum.net/ayuda - obtén información gratuita sobre la depresión relacionada con el embarazo y encuentra coordinadores en tu comunidad que te pueden brindar apoyo y recursos.
- 1.800.944.4773 - para recibir ayuda gratuita de manera inmediata y confidencial. (Se habla español).

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REFERENCES

- American College of Obstetricians and Gynecologists. (2016). Committee Opinion no. 658. Optimizing support for breastfeeding as part of obstetric practice. *Obstet Gynecol*, 127(2), 420-421. Available at <http://www.acog.org/Resources-And-Publications/CommitteeOpinions/Committee-on-Obstetric-Practice/Optimizing-Support-forBreastfeeding-as-Part-of-Obstetric-Practice>: American College of Obstetricians and Gynecologists. (2015). Committee Opinion no. 630. Screening for perinatal depression. *Obstet Gynecol*, 125, 1268-1271. Available at <http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-ObstetricPractice/Screening-for-Perinatal-Depression>: American College of Obstetricians and Gynecologists. (2008). Practice Bulletin no. 92. Use of psychiatric medications during pregnancy and lactation. *Obstet Gynecol*, 111, 1001-1020.
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC.
- Beck, C.T., & Gable, R.K. (2000). Pregnancy related depression screening scale: Development and psychometric testing. *Nurs Res*, 49(5), 272-282.
- Brouwers, E.P., Van Baar, A.L., and Pop, V.J., (2001). Does the Edinburgh Postnatal Depression Scale measure anxiety? *Journal of Psychosomatic Research*. 51(5): 659-63. Retrieved from <https://www.ncbi.nlm.nih.gov/pubmed/11728506>
- Cox, J.L., et al. (1987). Detection of postnatal depression. Development of the 10-item Edinburgh Postnatal Depression Scale. *Br J Psychiatry*, 150, 782-786.
- Earls, M.F. & American Academy of Pediatrics Committee on Psychosocial Aspects of Child and Family Health. (2010). Incorporating recognition and management of perinatal and pregnancy related depression into pediatric practice. *Pediatrics*. 126(5), 1032-1039. Available at <http://pediatrics.aappublications.org/content/126/5/1032>
- Grote, N.K., et al. (2009). A randomized controlled trial of culturally relevant, brief interpersonal psychotherapy for perinatal depression. *Psychiatr Serv*, 60(3), 313-21.
- Hirst, K.P., & Moutier, C.Y. (2010). Pregnancy related major depression. *American Family Physician*, 82, 926-933. Available at <http://www.aafp.org/afp/2010/1015/p926.html>
- Holden, K., Schmidt, A., & Willard, P. (Eds.). (2015). *ICD 10-CM: The complete official draft codebook* (15th ed.). USA: American Medical Association (AMA).
- Ip, S., et al. (2007). Breast feeding and maternal and infant outcomes in developed countries. Evidence Report/Technology Assessment No. 153. Prepared for the Agency for Healthcare Research and Quality, Rockville, MD. Available at <https://archive.ahrq.gov/clinic/tp/brfouftp.htm>
- Kim, J.J., et al. (2015). Suicide risk among perinatal women who report thoughts of self-harm on depression screens. *Obstet Gynecol*, 125(4), 885-93.
- Langan, R.C., & Goodbred, A. J. (2016). Identification and management of peripartum depression. *American Family Physician*, 93(10), 852-858.
- Loscalzo, Y., Giannini, M., Contena, B., et. al. , (2015). The Edinburgh Postnatal Depression Scale for Fathers: A contribution to the validation for an Italian sample. *Gen Hosp Psychiatry*. 37(3):251-6. Retrieved from <https://www.ncbi.nlm.nih.gov/pubmed/25724271>
- Meltzer-Brody, S., & Jones, I. (2015). Optimizing the treatment of mood disorders in the perinatal period. *Dialogues in Clinical Neuroscience*, 17(2), 207-218. Available at <http://www.dialogues-cns.org/publication/optimizingthe-treatment-of-mood-disorders-in-the-perinatal-period/>
- Mental Health Among Women of Reproductive Age in Colorado https://www.colorado.gov/pacific/sites/default/files/LPH_MCH_Issue-Brief-6_Mental-Health-Women.pdf
- Misri, S., Abizadeh, J., Sanders, S., & Swift, E. (2015). Perinatal Generalized Anxiety Disorder: Assessment and Treatment. *Journal of Women's Health*, 24(9), 762-770. <http://doi.org/10.1089/jwh.2014.5150>
- Myers, E.R., et al. (2013). Efficacy and safety of screening for pregnancy related depression. Comparative effectiveness review 106. Prepared for the Agency for Healthcare Research and Quality, Rockville, MD. Available at <https://www.effectivehealthcare.ahrq.gov/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productid=1438> Accessed 7/29/2016 from <http://www.effectivehealthcare.ahrq.gov/index.cfm/search-for-guidesreviews-and-reports/?producttypes=&search=&trackID=&language=1&methodCategory=>

&category=&statusType=3&agencyType=2&sortBy=topicDate.

Norhayati, M.N., et al. (2015). Magnitude and risk factors for pregnancy related symptoms: A literature review. *J Affect Disord*, 175, 34-52.

North, C. S., & Yutzy, S. H. (2010). *Goodwin and Guze's Psychiatric Diagnosis* (6th ed.). New York, NY: Oxford University Press.

O'Connor, E., et al. (2016). Primary care screening for and treatment of depression in pregnant and pregnancy related women: Evidence report and systematic review for the US Preventive Services Task Force. *JAMA*, 315, 388-406.

O'Hara, M., & Scott, S. STEP-PPD: Support and training to enhance primary care for pregnancy related depression [Online course]. Retrieved from Danya International, Inc. Web site: <http://www.step-ppd.com/step-ppd/Home.aspx>
OPTUM™ CPT® Data Files. (2016) Salt Lake City, UT. Optum Coding - Ingenix. STAT!Ref Online Electronic Medical Library. Retrieved from <http://online.statref.com/Document.aspx?fxId=24&docId=1> on 8/18/2016.

Pregnancy Related Depression, Colorado Department of Health and Environment:
<https://www.colorado.gov/pacific/cdphe/pregnancy-related-depression-resources-providers>

Postpartum Support International:
<http://www.postpartum.net/colorado/>

Sachs, H.C. & American Academy of Pediatrics Committee on Drugs. (2013). The transfer of drugs and therapeutics into human breast milk: An update on selected topics. *Pediatrics*, 132(3), e796-809. Available at <http://pediatrics.aappublications.org/content/132/3/e796.long>

Shellman, L., et al. (2014). Pregnancy related depression in immigrant Hispanic women: A comparative community sample. *J Am Assoc Nurse Pract*, 26(9), 488-97.

Sriraman, N.K., et al. (2015). ABM Clinical Protocol #18: Use of antidepressants in breastfeeding mothers. *Breastfeeding Medicine*, 10(6), 290-299.

Weissman, A.M., et al. (2004). Pooled analysis of antidepressant levels in lactating mothers, breast milk, and nursing infants. *Am J Psychiatry*, 161, 1066-1078.

Yawn, B.P., et al. (2009). Concordance of Edinburgh Postnatal Depression Scale (EPDS) and Patient Health Questionnaire (PHQ-9) to assess increased risk of depression among pregnancy related women. *J Am Board Fam Med*, 22(5), 483-491. Available at <http://www.jabfm.org/content/22/5/483.long>

Zero Suicide Advisory Group (2015). Zero suicide toolkit. Retrieved from <http://zerosuicide.sprc.org/>

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