

# Parental Depression Screening: Moderate to Severe Screening Results

Sandra Wood, CNM, PMHNP

UVMMC Women's Health Care Service

Sarah Guth, MD, Child & Adolescent Psychiatrist

UVMMC Child Psychiatry

# Disclosures

- Sandra Wood, CNM, PMHNP
  - I have no relevant financial relationships to disclose or conflicts of interest to resolve
  - I will not discuss unapproved or off-label pharmaceuticals
- Sarah Guth, MD
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# Perinatal Mood and Anxiety Disorders

- Perinatal:
  - Preconception
  - Pregnancy
  - The first year post partum
- Spectrum of Emotional Distress
  - Depression
  - Anxiety
  - Post Traumatic Stress Disorder
  - Obsessive Compulsive Disorder
  - Psychosis

# Post partum Blues - Not a disorder

- 50-80%
- found in all cultures
- Unrelated to past mental health or psychosocial stressors
- May last a few hours to 14 days
- Responds to supportive interventions
- Still future oriented, worries are not unmanageable, predominant mood is happiness
- Symptoms:
  - Tearfulness
  - Mood fluctuation, sadness, irritability
  - Anxiety
  - Increased emotional reactivity and intensity

# Depression

- Onset during pregnancy or first year postpartum. Peaks at 3-4 months postpartum. Can also be triggered by weaning and/or when menstrual cycle resumes.
- Symptoms
  - Depressed Mood. Change in appetite, sleep, energy, motivation, concentration. Negative thinking including guilt, hopelessness, helplessness, and worthlessness. May also experience suicidal thoughts and evolution of psychotic symptoms.
- Risk factors:
  - History of Personal history of depression or anxiety perinatal mood/anxiety disorder
  - Family history of depression or anxiety
  - Recent, big life changes (in addition to pregnancy/new baby)
  - Lack of social support, poor marital/partner relationship
  - Multiples
  - Difficult pregnancy
  - Difficult infant temperament (colic, fussy) or related problems (sleep, feeding)
  - Special needs/NICU baby
  - Infertility treatments, prior pregnancy or infant loss
- Up to 21.8% prevalence in the first postpartum year.

# Depression

- In a study of 10,000 mothers:
  - 26.5% episode with onset prior to pregnancy in a chronic pattern
  - 33.4% onset in pregnancy
  - 40.1 onset in the PP period
  - 68.5% unipolar
  - 66% comorbid anxiety (most often GAD)
  - 22.6% diagnosed with BPD with depressive presentation
  - 19.3 endorsed thoughts of self harm
- Bipolar II
  - Especially vulnerable to severe depression
  - Potential for an initial hypomanic phase
    - Full of energy Need little sleep
    - Lapse into a depression several weeks later
- 50% of women with Bipolar disorder are diagnosed postpartum-  
60% present with depression

# Symptoms of Men's Depression

- Increased anger and conflict with others
- Increased use of alcohol or other drugs
- Frustration or irritability
- Violent behavior
- Losing weight without trying
- Isolation from family and friends
- Being easily stressed
- Impulsiveness and taking risks, like reckless driving and extramarital sex
- Feeling discouraged
- Increases in complaints about physical problems
- Ongoing physical symptoms, like headaches, digestion problems or pain
- Problems with concentration and motivation
- Loss of interest in work, hobbies and sex
- Working constantly
- Frustration or irritability
- Misuse of prescription medication
- Increased concerns about productivity and functioning at school or work
- Fatigue
- Experiencing conflict between how you think you should be as a man and how you actually are
- Thoughts of suicide

<http://postpartummen.com/>

# Anxiety

- Onset in the perinatal period. Can also be triggered by weaning and/or when menstrual cycle resumes
- Symptoms
  - Fear and anxiety, panic attacks, shortness of breath, rapid pulse, dizziness, chest or stomach pains, feelings of detachment/doom, fear of going crazy or dying. Excessive, debilitating worry. May have intrusive thoughts.
- Risk factors
  - as per depression.
  - Preexisting anxiety symptoms or trait anxiety.
- General Anxiety Disorder
  - 6% antepartum
  - 10% postpartum
  - **Twice the incidence in general population**
- Panic disorder: 0.5-3%
- Social anxiety: 0.2-7%
  
- Not typically targeted for screening



# Postpartum Post Traumatic Stress Disorder

- Onset
  - At birth or within the first 6 to 8 weeks
- Symptoms:
  - Change in cognition, mood, arousal associated with traumatic event(s) and avoidance of stimuli associated with traumatic event.
  - Specific anxiety symptoms, including nightmares, flashbacks, and hyper vigilance, experienced after traumatic events(s), including a traumatic birth, infant in NICU
- Risk factors as Depression, Anxiety, and OCD, plus:
  - perception of traumatic birth
  - Previous sexual trauma.
- 9% screen + for meeting criteria for PTSD
- 18% experience elevated levels of PTSD symptoms
- Up to one-third of women report a labor/birth that fulfills the criteria for a traumatic event.
  
- **? What about Fathers?**

# Postpartum Obsessive Compulsive Disorder

- Onset postpartum
- Postpartum Scary thoughts.
  - Negative unwanted, disturbing, intrusive, repetitive thoughts or images (which may include harming baby or fear of harm coming to baby), that don't make sense to the parent
  - Ego dystonic. These thoughts are distressing to the mother and she will do what she needs to keep the baby safe.
  - Compulsions (e.g. counting, hand washing) may or may not be present but there may be adaptive compulsive behavior to prevent baby from being harmed
- 11% (population risk 2-3%)
  - Common symptom of PPD
  - 41% of women with non-psychotic PPD will experience
  - 91% mothers and 88% fathers report them some point.

# Postpartum Psychosis

- Sudden onset of psychotic symptoms following childbirth, in particular delusions regarding self and/or child(ren)
- Symptom rather than a syndrome
  - Major depressive disorder.
  - Bipolar disorder
- Early onset
  - between 2 – 12 weeks after delivery.
  - Watch carefully if sleep deprived for  $\geq 48$  hours.
- Confusion, disorientation, delusions, hallucinations, insomnia, rapid mood swings,
  - Symptoms may come and go. < 20% of women reveal symptoms
  - Close family are more likely to see the extreme behavioral symptoms. May act frightened or paranoid
  - Thought of harming baby that are not recognized as foreign. Ego syntonic
- Increased risk
  - Bipolar disorder, personal or family history of psychosis/postpartum psychosis (80% relapse)
  - severe sleep deprivation
  - medication discontinuation for bipolar disorder (especially when done quickly).
  - family history
    - Bipolar disorder
    - Schizophrenia
- RARE 1.1 to 4.0 per 1000 births.
- Suicide/infanticide is a significant risk
- **This is psychiatric emergency**

## Key Clinical Considerations

### When Assessing the Mental Health of Postpartum Women

- Thoughts of harming baby that occur secondary to obsessions/anxiety:
  - Good insight
  - No psychotic symptoms
  - Thoughts are intrusive, scary, and cause mother anxiety
  - Ego-dystonic
- Suggests not at risk of harming baby
  
- Thoughts of harming baby that occur secondary to postpartum psychosis:
  - Poor insight
  - Symptoms of psychosis (eg. auditory and/or visual hallucinations)
  - Delusional beliefs with distortion of reality present
  - Ego-syntonic
- Suggests at risk of harming baby

# Responding to Scores

- **EPDS**
  - 9 or less no depression concerns
  - 10 to 12 modest concern
  - 13 to 18 moderate concern
  - 19 and above likely to have depression
  - Any positive score on item 10
- **PHQ9**
  - <5 normal
  - 5-9 mild or minimal depression symptoms
  - 10-14 moderate symptoms
  - 15-19 moderately severe symptoms
  - = 20 severe symptoms
  - Any positive score on item #9

# Crisis Action Plan

If parent answered “YES” to #10/EPDS or #9 PHQ9 or reports thoughts of harm to self or others:

Limits of confidentiality should be explicitly set out. For example, "Everything we talk about stays here unless I hear you are going to hurt yourself or someone else or someone is hurting you".

- **Ask further questions:**
  - **Intent:** “You have said that you think about killing or harming yourself. Have you made any plans?”
  - **Means:** “Can you describe your plans? How have you thought about killing yourself (your infant)? Do you have access to [stated method]?”
  - **Likelihood:** “Do you think you would actually harm or kill yourself or someone else?”
  - **Protective Factor:** “What is keeping you from following through with your plan?”
  - **Impulsivity:** “Have you tried to harm yourself or someone else in the past?”
- **If parent has a plan and provider or parent feels s/he cannot be safe follow these steps:**
  - Do not leave patient by herself or alone with baby
  - Contact and engage supportive person in their life (partner, relative, friend)
  - Make this person aware of current circumstance
  - Engage them to plan for: child care, transportation to emergency services, emotional support
- **Coordinate immediate psychiatric/crisis intervention or evaluation:**
  - Be familiar with Emergency Department policies and referral processes
  - When no resources are available, call 911
- **If parent is not in the office and feels s/he cannot be safe or worries if she will be safe follow these steps:**
  - Ask where s/he is and if s/he is alone
  - Assess degree of risk
  - Arrange for immediate psychiatric/crisis intervention or evaluation while parent remains on phone
  - Assess availability and proximity of resources and support

# Adequate Evaluation

## Diagnostic Clarity: Review of Psychiatric Symptoms

- Obsessive or intrusive thoughts?
- Paranoia?
- Delusions?
- Hallucinations?
- Insomnia? (unrelated to infant care)
- Increase in goal-related activity
- Panic
- Agoraphobia
- Substance use
- Depressive symptoms
- Trauma Symptoms
- Racing thoughts
- Anxiety

# Adequate Evaluation

- Psychiatric History:
  - History of similar symptoms
  - Severity: Hospitalizations or Suicide Attempts
  - Treatment history: \* Especially medicines\*
  - Family history of psychiatric problems



# Adequate Evaluation

## Lifestyle Assessment:

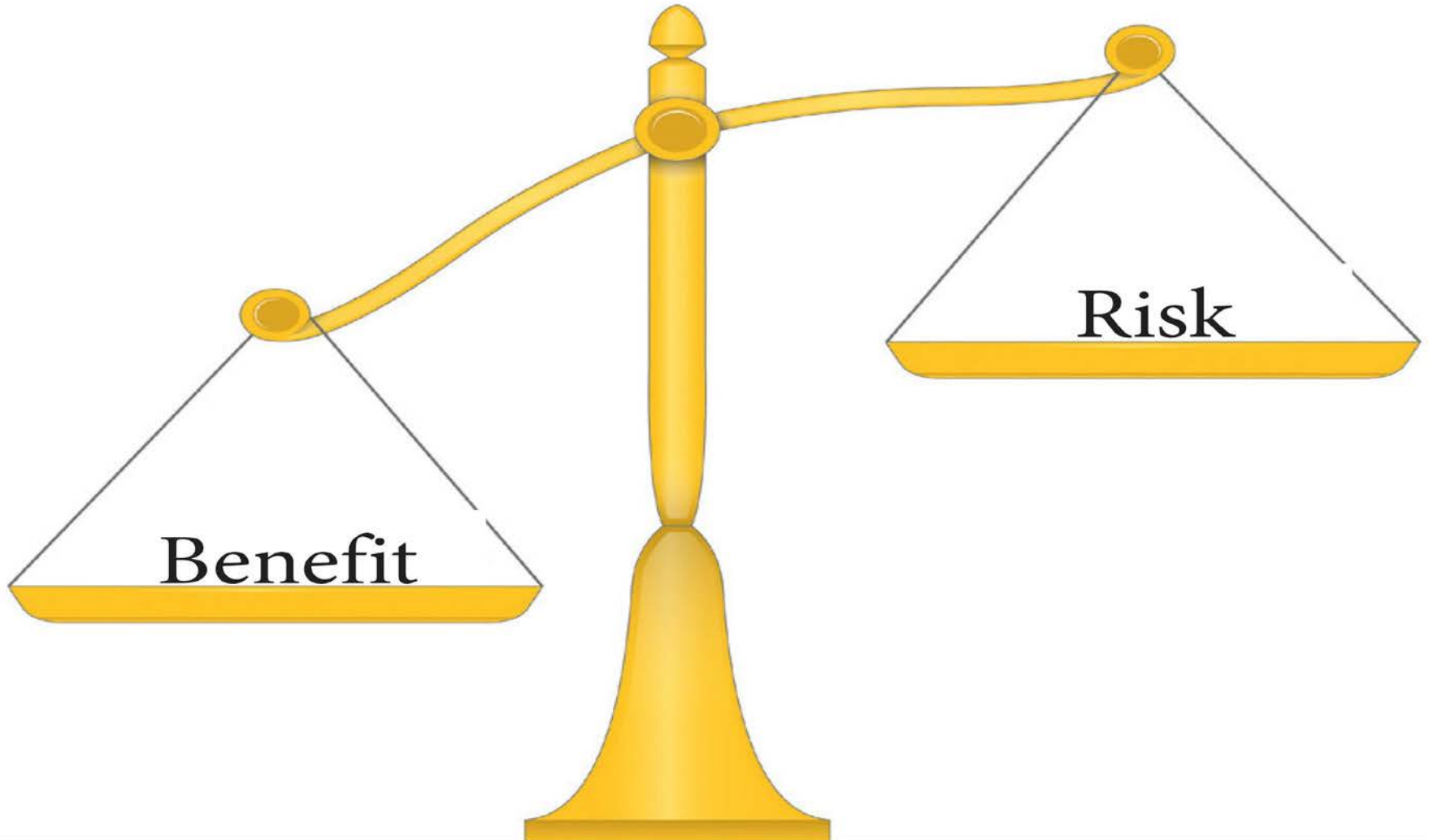
- Parenting Support
- Stress
- Social isolation
- Sleep
- Work (time off)
- Physical Activity
- Nutrition

# Treatment

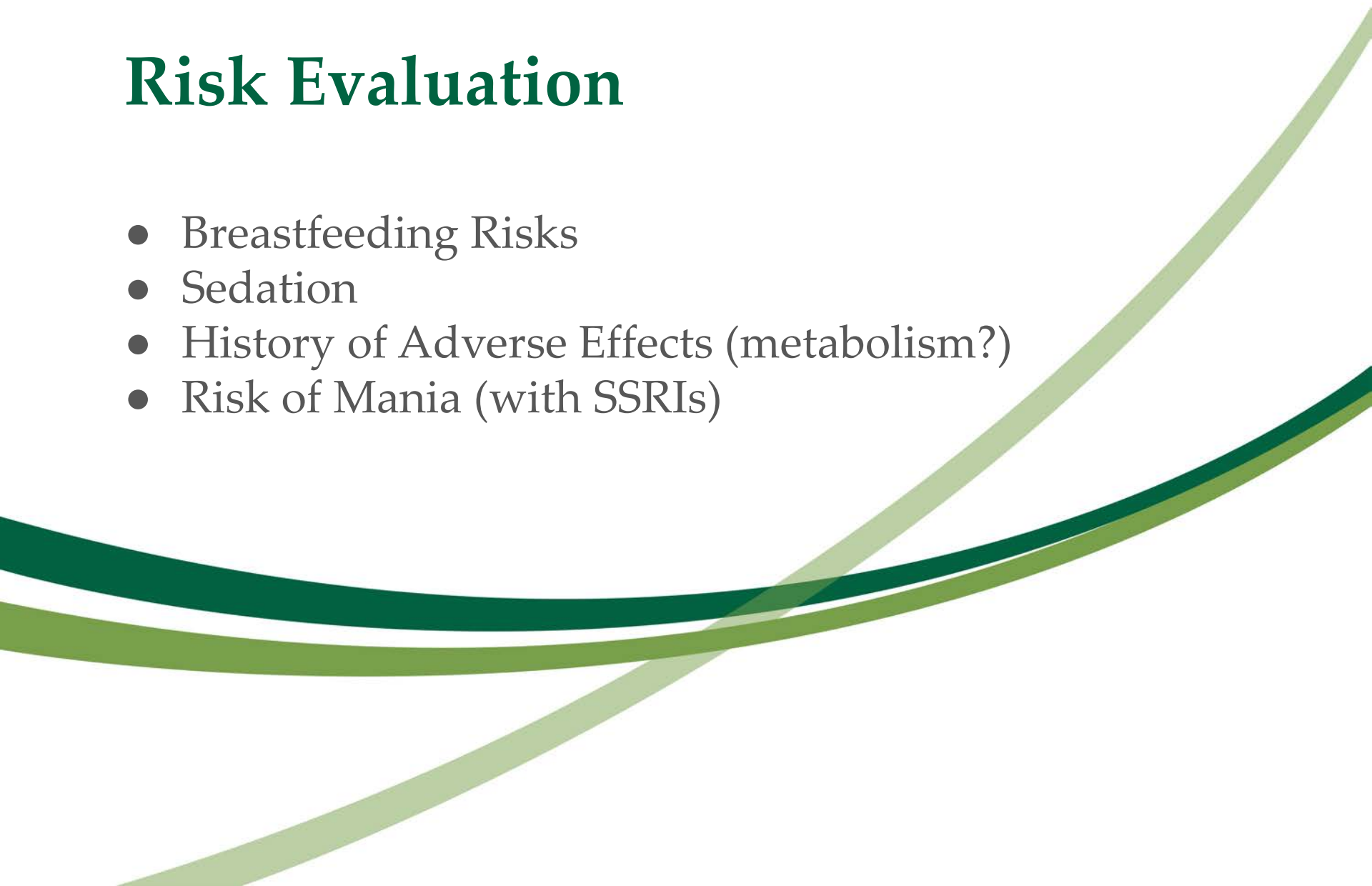
Before medicine is even on the table....

- Assess best place for woman to be: home, with family member or friend, crisis bed, hospital?
- Find ways to increase support, time for self-care
- Evidence-Based Psychotherapy
- Physical activity, Meditation (mindfulness apps), Support groups

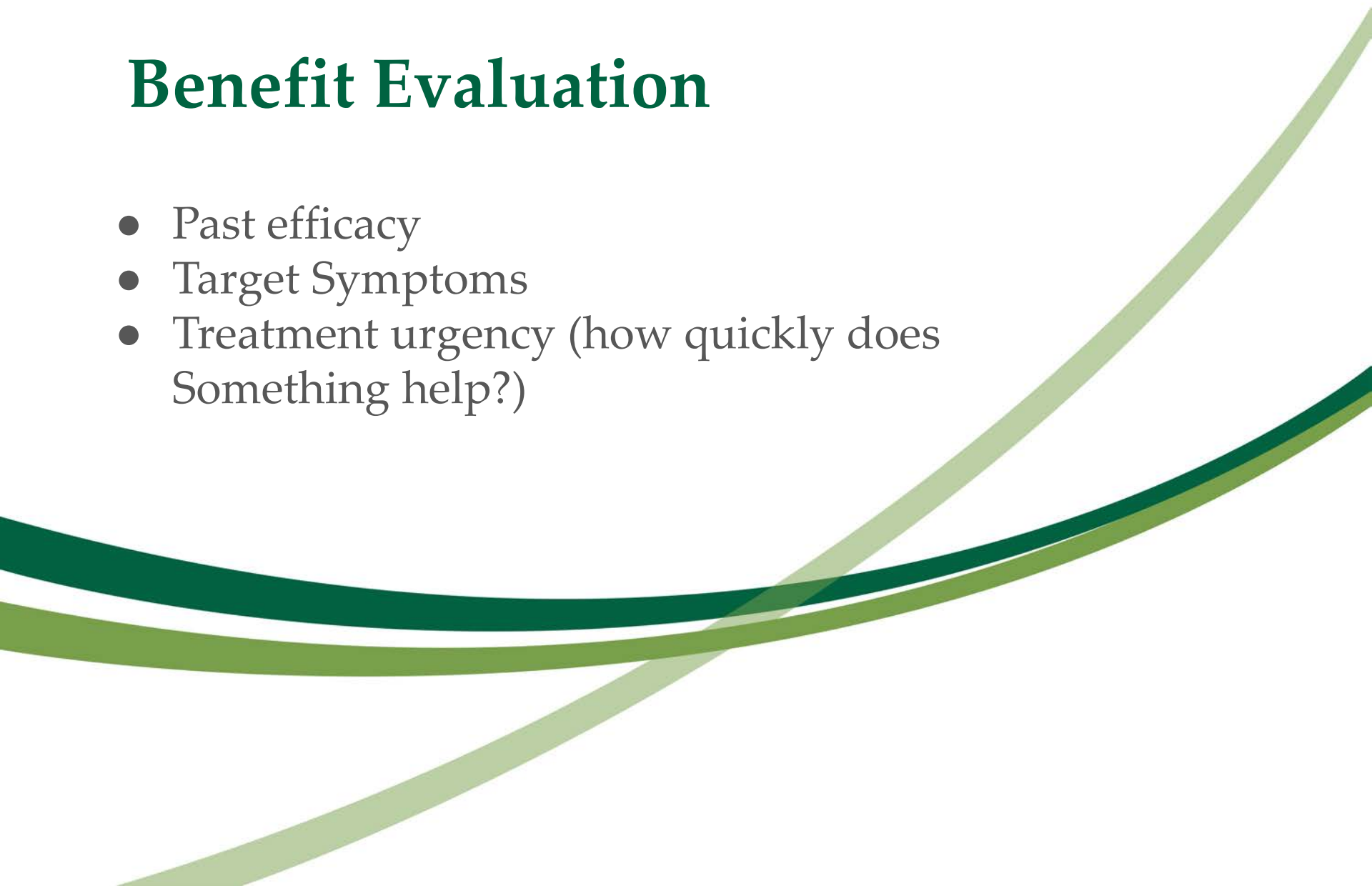
# Medications



# Risk Evaluation

- Breastfeeding Risks
  - Sedation
  - History of Adverse Effects (metabolism?)
  - Risk of Mania (with SSRIs)
- 

# Benefit Evaluation

- Past efficacy
  - Target Symptoms
  - Treatment urgency (how quickly does Something help?)
- 

# Breastfeeding Safety

SSRI's: Best Studied  
Low Passage (most), Well tolerated

Best:

- Sertraline
- Fluvoxamine
- Paroxetine (\*\* Very short half life)

Worst (Higher rate of passage, more side effects)

- Prozac
- Celexa
- Lexapro

# Breastfeeding Safety

## SSRI Potential Side Effects:

- Fussiness
- Poor Feeding
- Somnolence/Lethargy
- Tone changes- usually hypotonia
- Potential for withdrawal with cessation of breastfeeding

# Breastfeeding Safety

Other common antidepressants:

Bupropion: Only about 2% of maternal dose found in infant plasma, but two case reports of seizures

Venlafaxine: Variable passage rate (5- 40%) but no adverse effects

Mirtazapine: 2% or lower of maternal dose- no adverse effects



# Antipsychotics

- Treat Psychosis
- Stabilize Mood
- Severe OCD
- Work quickly
- May not need for long (less worry of long-term effects)
- Augment antidepressant if already on one
- Relatively well studied in breastfeeding
- Some are sedating

# Antipsychotics

- Mostly low levels found in breastmilk
- **Olanzapine** best studied- used worldwide
- Quetiapine and risperidone also deemed safe alternatives
- Low risk of side effects (less than 2%):
  - Somnolence
  - Poor feeding
  - Tremor
  - Irritability
- Long term developmental studies reassuring

# Benzodiazepines

- Most often used with extreme anxiety or insomnia as PRN
- Can use while waiting for SSRI
- Must first use with support present (some people very sensitive to sedation)
- Prefer shorter/intermediate acting agents
- **Lorazepam** is generally not sedating for infants
- **Clonazepam** linked to most sedation in infants

# Role of Pediatrician

- Ask about their symptoms (re-screen if necessary)
- Assess their follow up plan
- Address barriers for follow up
  - Agoraphobia?
  - Maybe another support person needs to be involved?
  - Fear of DCF involvement? Be ready to reassure women that asking for help does NOT mean their baby will be removed- often the opposite- DCF WANTS to see women asking for help)
  - If they won't/can't meet a psychiatrist, at least recommend follow up with PCP and therapist.
- Have a list of providers ready to refer to if necessary

# Medication Resources

- **LactMed – Drugs and Lactation Database**

- <http://toxnet.nlm.nih.gov/newtoxnet/lactmed.htm>

- Contains information on drugs and other chemicals to which breastfeeding mothers may be exposed. Includes information on the levels of such substances in breast milk and infant blood, and the possible adverse effects in the nursing infant. Suggested therapeutic alternatives to those drugs are provided, where appropriate. All data are derived from the scientific literature and fully referenced. Child-bearing age women
- Free

- **Motherisk**

- [www.motherisk.org](http://www.motherisk.org)

- Helpline for mothers and health care providers
- 1-877-439-2744
- Provides evidence-based information and guidance about the safety; or risk to the developing fetus/infant; of maternal exposure to drugs, chemicals, diseases, radiation and environmental agents. Child-bearing age women
- Free

- **MothertoBaby**

- <http://www.mothertobaby.org/>

- Helpline for mothers, health care professionals, and the general public
- 1-866-626-6847
- Provides evidence-based information about medications and other exposures during pregnancy and while breastfeeding
- free

# References

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Questions?

