THE POSTPARTUM *DEPRESSION* TOOLKIT for PEDIATRIC *THERAPISTS* *in EARLY INTERVENTION*

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a therapist's guide to postpartum depression screening.

The Postpartum Depression Screening for Pediatric Therapists was adapted with permission from MCPAP for Moms. This toolkit is recommended for use by therapist in the Lo Angeles area. Please contact Apple Sepulveda (applesepulveda1@gmail.com) for questions. Thank you for the contributions of Nicholas Kasovac, OTS and Isabele Magbanua.

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POSTPARTUM DEPRESSION TOOLKIT for PEDIATRIC *THERAPISTS*

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The Postpartum Screening program is a screening and referral system for at-risk mothers of babies from 0-24 months of age seen by pediatric therapy providers. The program aims to identify mothers with PPD in pediatric settings by:

01 Introducing a screening toolkit and training tools to assist the therapists in screening, scoring, interpreting scores, educating, and referral.

02 Presenting a comprehensive list of resources of support services in the community

The Early Intervention Postpartum Depression Screening program is a screening and referral system for at-risk mothers of babies from 0-24 months of age seen by pediatric therapy providers. The program aims to identify mothers with PPD in pediatric settings by:

01 Increase the therapists' awareness of the importance of screening and the impacts of depression in new mothers;

02 Provide routine screening using Edinburgh Postpartum Depression Scale (EPDS) for mothers of babies ages 0-24 months;

03 Increase therapists' confidence levels necessary to perform screenings, discuss results, and provide resources to mothers at risk for depression.

Screen! *Because you can't tell a mother* ***has postpartum depression just by looking...***

The toolkit includes:

01 Postpartum depression: What is it?

02 Screening for postpartum depression screening and billing

03 Perinatal Mood and Anxiety Disorders Fact Sheet

04 Considerations for Assessing the Mental Health of Pregnant and Postpartum Women

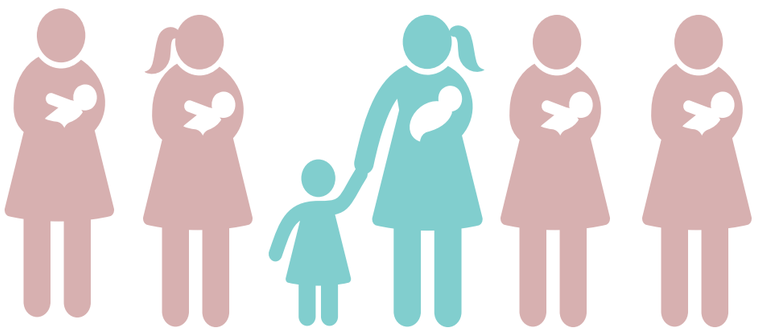
05 Edinburgh Postnatal Depression Scale (EPDS), Screening Tool, Algorithm, and Scoring Guide

06 Suggested talking points and language for discussion with mothers on scores and results of the screening.

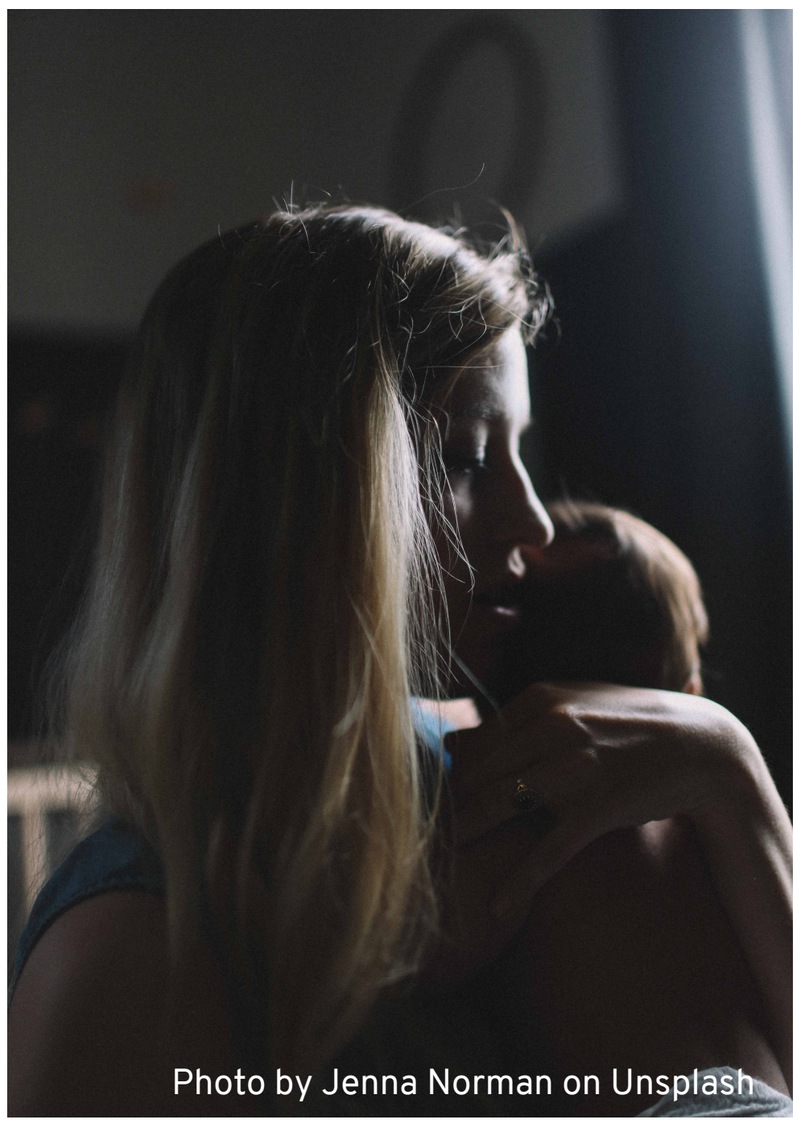
07 Crisis plan for mothers with suicidal ideation (+ score for EPDS #10)

08 Referral pathyways and list of community resources.

POSTPARTUM *DEPRESSION*



1 in 5 mothers experience postpartum depression



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Background

Postpartum depression (PPD), the most common complication of childbirth, affects approximately 1 in 5 women (Wisner et al., 2013). This public health crisis impacts the mother and the baby, the family, and society. Maternal depression is correlated with poor parental sensitivity, unsafe parenting practices, low breastfeeding rates, and increased susceptibility to child abuse and neglect (Balbierz et al., 2015; Challacombe et al., 2016; Earls et al., 2019). These effects pose long-term consequences to the baby, including developmental delays, weight gain concerns, and disturbances in social-emotional development (Van Der Zee-Van Den Berg et al., 2017). Maternal depression also contributes to family instability, such as financial and relationship strains (Edward et al., 2015). On a larger scale, the estimated annual societal cost of untreated maternal depression in the United States for mother and baby is $14 billion (Luca et al., 2020).

Why is postpartum depression important to pediatric therapy providers?

While the general prevalence of PPD is approximately 20%, mothers of children at risk for developmental delays are at much higher risks. Mothers of preterm babies and babies with low birth weights are 44% likely to suffer postpartum depression, and stays in neonatal intensive care units suffer increased rates of acute and posttraumatic stress symptoms (Vigod et al., 2010). Similarly, adoptive parents experience depression at similar rates as birth parents (Mott et al., 2011). Mothers with preterm infants are also likely to need parenting support in the early stages of the child's life, especially after discharge from the NICU (Tahirkheli et al., 2014).

Maternal depression in pregnancy is associated with preterm births, which are also correlated to long-term impacts on the child's overall health and development (Agnafors et al., 2013). Depression and anxiety correlate with adverse child outcomes such as attachment problems, behavioral issues, physical, cognitive, and language development delays (Glover, 2014; Letourneau et al., 2012) Correlated with unsafe parenting practices and decreased sensitivity to the child's needs, maternal depression can lead to abuse and neglect (Balbierz et al., 2015). Consequently, depressed parents of children with developmental concerns need to be highly sensitive to follow through therapy plan of care (Reynolds et al., 2012). However, depression can decrease their engagement in therapy services (Alvarez et al., 2015). On the same note, children's developmental delays further increase and contribute to the parent's depression. These dual challenges call for therapists' involvement in supporting and screening mothers for depression to ensure that the mothers are supported, and the child's developmental needs are met. The intersection of developmental outcomes and maternal-infant mental health puts therapists in a crucial position to screen mothers for postpartum depression.

Source: Adapted from Massachusetts Child Psychiatry Access Project for Moms' Postpartum Depression Screening Algorithm for Pediatric Providers During Well-Child Visits, available at www.mcpapformoms.org and the DChealth

Who are at risk?

PPD is associated with maternal factors, such as age, hormonal imbalance, mother's previous history of depression, abuse, and neglect (Ghaedrahmati et al., 2018; Silverman et al., 2017). Moreover, experiences related to pregnancy, birth, and the child's medical condition also increases the likelihood of getting the disorder. (Ghaedrahmati et al., 2018; Silverman et al., 2017). Mothers experiencing depression in pregnancy are likely to encounter depression after the child's birth. Preterm births increase the probability for mothers to get postpartum depression. Estimated the rates of up to 40% of mothers of preterm babies and babies with low birth weight (Vigod et al., 2010). This research suggests medical comorbidities can contribute to increasing levels of stress. Maternal depression is positively correlated with mothers of babies admitted to the neonatal intensive care unit (NICU) stays (Vigod et al., 2010).

Psychosocial factors are also correlated with PPD risk. Financial struggles experienced by people living in poverty, such as inadequate pay, unstable housing, and the decreased ability to afford basic needs, can compound daily life stressors such a having a new baby (Segre et al., 2006). Unmarried and unpartnered women with high school diplomas or less and the users of public insurance have higher chances of experiencing PPD (Keating-Lefler & Wilson, 2004; Liu & Tronick, 2013; Sherman & Ali, 2018). Regardless of social status, inter-partner violence victims also experience high distress levels after the baby's birth (Kothari et al., 2016). Furthermore, race and ethnicity are found to have considerable roles in the prevalence of PPD. Women from Black, Latin, and Asian-Pacific backgrounds are likely to experience postpartum depression than White mothers (Liu & Tronick, 2013; Pao et al., 2019). Finally, the lack of support is found to put women at higher risks for PPD across all sociodemographic backgrounds (Pao, Kuriakose, 2020, Segre 2016, Letourneau et al., 2012).

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Postpartum Depression in Fathers

Fathers also experience postpartum depression with an estimated 4 to 25% (Goodman et al., 2004). Moreover, depressive symptoms in fathers spike 3-6 months postpartum (Paulson & Bazemore, 2010). Paternal postpartum depression is highly correlated with maternal depression, thereby warranting attention (Burke, 2003). Paternal depression is linked to adverse child outcomes, such as conduct disorder and depression, and harmful parenting practices, such as increased incidence of spanking (Gutierrez et al., 2015, 2019; Glasser & Lerner-Geva, 2019). Postpartum depression symptoms may differ in fathers than mothers. It may manifest as anger, irritability, aggressiveness, hostility, distancing, distractibility, and self-isolation (Singley & Edwards, 2015). Men with depression tend to underreport symptoms and are more likely to report substance abuse and disturbances in work and social functioning (Oliffe & Phillips, 2008; Fisher, 2017). Furthermore, increases in anxiety, depression, and parental stress predicted less mental health support seeking (Isacco et al., 2016).

Source: Adapted from Massachusetts Child Psychiatry Access Project for Moms' Postpartum Depression Screening Algorithm for Pediatric Providers During Well-Child Visits (mcpapformoms.org and DC Collaborative for Mental Health in Pediatric Primary Care Children's National Hospital

POSTPARTUM *DEPRESSION* ***SCREENING***

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Public health and policy efforts have increased the awareness of PPD and the recognition for screening, support, and treatment. Of note, the U.S. Preventive Services Task Force has recommended postpartum depression screening (Sui & US Preventative Services Task Force, 2016). Similarly, the American Congress of Obstetricians and Gynecologists, the American Academy of Pediatrics, and the Center for Medicaid and Medicare Services call for screening new mothers for maternal mental health disorders, including postpartum depression (Committee on Obstetric Practice, 2018; Olson et al., 2006; Wachino, 2016)

The systemic barriers, such as the fragmented mental and physical health systems, inadequate provider training, limited provider access, and the shortage of mental health providers, have contributed to the slow uptake of screening and treatment and the research-to-practice translation gaps (Gjerdingen & Yawn, 2007). Besides, the question of which provider should be screening mothers contribute to the challenge. Due to the frequency of their contact with mothers in well-baby visits, pediatricians are recommended to screen for PPD and refer mothers to support services to address these gaps (Earls et al., 2019). Furthermore, they are encouraged to refer mothers to services and treatment (Van Der Zee-Van Den Berg et al., 2017). Similarly, pediatric therapy providers also see an increasing need to screen and refer the mothers of babies served in early intervention. The lack of awareness and training contributes to the barriers to screening and detection of postpartum depression in mothers in pediatric clinics.

Billing for Postpartum Depression

Medi-Cal, California's Medicaid program, reimburses for depression screening as an outpatient service (California Department of Health Care Services, 2020). Additionally, screening must ensure appropriate follow-up and referral to mental health specialists. See this link from Medi-Cal for information:

https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/prev.pdf

Billing Codes:

	POSITIVE SCREEN	NEGATIVE SCREEN
Pregnant or postpartum period (0-12 months)	G8431 with modifier HD	G8431 with modifier HD
Age 12 and older, not pregnant or postpartum (12-24 months)	G0444 with modifier KX	96127

Source: Adapted from Massachusetts Child Psychiatry Access Project for Moms' Postpartum Depression Screening Algorithm for Pediatric Providers During Well-Child Visits (mcpapformoms.org and DC Collaborative for Mental Health in Pediatric Primary Care Children's National Hospital

Perinatal Mood and Anxiety Disorders Fact Sheet

Perinatal Mood and Anxiety Disorders (PMADs) are disorders that occur in pregnancy or the perinatal period that impact the mother's daily functioning. Contrary to the "Baby Blues" where the mother experience emotional disturbance by 2-5 days after delivery up to two weeks postpartum, PMADs usually lasts longer and happens during pregnancy of within the first year postpartum (O'hara & Wisner, 2014). The "Baby Blues usually resolves without intervention; however, support and psychoeducation may be helpful.

DISORDER	WHAT IT IS	HOW COMMON IS IT?	WHAT HAPPENS	WHEN IT STARTS HAPPENING	RISK FACTORS	RESOURCES AND TREATMENT
Perinatal Depression	Depression during pregnancy or within the first year of giving birth of the baby	Occurs in up to 20% of all new mothers. Low SES: 33-50%	Change in appetite, sleep, energy, motivation, concentration, hypervigilance Negative thinking including guilt, hopelessness, helplessness, and worthlessness. May also experience suicidal thoughts and evolution of psychotic symptoms.	Can occur during pregnancy or with the first year about the child's birth. Commonly happens after 3 months and can be triggered by weaning or when mother's menstrual cycle resumes.	History of perinatal mood/anxiety disorder Personal history of depression or anxiety 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 Prior pregnancy or infant loss Infertility PTSD: Traumatic birth (as experienced by mother) and/or Previous sexual trauma	Self-Care: Exercise, Sleep, Nutrition, Time off from childcare Peer Support Groups Psychotherapy (Individual, Dyadic [mother-baby], Couples, Family) Medication Additional complementary and alternative therapy options for depression include bright light therapy, Omega-3, fatty acids, acupuncture and folate.
Perinatal Anxiety	A range of anxiety disorders, including generalized anxiety, panic disorder and/or social anxiety, experienced during pregnancy or the postpartum period.	Generalized anxiety: 6-8% Panic disorder: 0.5-3% Social anxiety: 0.2-7%	Fear and anxiety, panic attacks, shortness of breath, rapid pulse, dizziness, chest or stomach pains, fear of detachment/doom, fear of going crazy or dying. Excessive sometimes debilitating worry. May have intrusive thoughts (see OCD).			
Obsessive-Compulsive Disorder (OCD)	Intrusive repetitive thoughts that are scary and do not make sense to mother/expectant mother. Compulsions (e.g., counting, hand washing) may or may not be present.	Reported in up to 4% of new mothers; likely higher due to fear of reporting.	Disturbing repetitive and invasive thoughts (which may include harming baby), compulsive behavior (such as checking) in response to intrusive thoughts.			
Post-traumatic Stress Disorder (PTSD)	Specific anxiety symptoms, including nightmares, flashbacks, and hyper- vigilance, experienced after traumatic events(s), including a traumatic birth.	Presents after childbirth in 2- 9% of mothers.	Change in cognition, mood, arousal associated with traumatic event(s) and avoidance of stimuli associated with traumatic event.			
Postpartum Psychosis	Sudden onset of psychotic symptoms following childbirth, in particular delusions regarding self and/or child(ren). Increased risk with bipolar disorder	Occurs in 1-2 in 1,000 births.	Mood fluctuation, confusion, marked cognitive impairment. Bizarre behavior, insomnia, visual and auditory hallucinations. May have moments of lucidity. May include altruistic delusions about infanticide and/or homicide and/or suicide	Onset between 2 – 12 weeks after delivery. Watch carefully if sleep deprived for ⩾48 hours.	Bipolar disorder, history of psychosis, history of postpartum psychosis (80% will relapse), family history of psychotic illness, severe sleep deprivation, medication discontinuation for bipolar disorder (especially when done quickly	Requires immediate psychiatric help. • Hospitalization and medication are usually indicated. • If history of postpartum psychosis, preventative treatment is needed in subsequent pregnancies. Encourage sleep hygiene for prevention (e.g. consistent sleep/wake times, help with feedings at night).

Source: Adapted from Massachusetts Child Psychiatry Access Project for Moms' Postpartum Depression Screening Algorithm for Pediatric Providers During Well-Child Visits (mcpapformoms.org and DC Collaborative for Mental Health in Pediatric Primary Care Children's National Hospital

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Considerations for Assessing the Mental Health of Pregnant and Postpartum Women

How to Talk about Perinatal Depression 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?**
- **How are you sleeping?**

Assessing Thoughts of Harming Baby

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

About Medications

Factors Indicating Medication May Not be Necessary:

• Mild depression based on clinical assessment
• No suicidal ideation
• Able to care for self/baby
• Engaged in psycho-therapy or other non-medication treatment
• Depression has improved with psychotherapy in the past
• Strong preference for and access to psychotherapy

Factors Indicating Medication Needs To Be Considered:

• Moderate or severe depression based on clinical assessment
• Suicidal ideation
• Difficulty functioning caring for self/baby
• Psychotic symptoms present
• History of severe depression and/or suicidal ideation and/or attempts
• Comorbid anxiety diagnosis or symptoms

Source: Adapted from Massachusetts Child Psychiatry Access Project for Moms' Postpartum Depression Screening Algorithm for Pediatric Providers During Well-Child Visits (mcpapformoms.org and DC Collaborative for Mental Health in Pediatric Primary Care Children's National Hospital

EDINBURGH *POSTNATAL* DEPRESSION SCREENING SCALE

The EPDS is a validated scale created for screening mothers with depression. It consists of 10 short statements which the mother picks the closest response to how she has been feeling in the last seven days. Response categories are scored 0, 1, 2, and 3 according to increased severity of the symptom. Items 3 and 5-10 are reverse scored (i.e., 3, 2, 1, and 0). The total score is calculated by adding together the scores for each of the ten items. Most mothers need less than 5 minutes to complete the scale.

The validation study showed that mothers who scored above a threshold of 12/13 were likely to be suffering from a depressive illness of varying severity. However, a recent study recommends using a severity scale as the threshold enforces a yes/ no categorization. The severity scale is found to be more sensitive to the detection of postpartum depression. The following severity scales are determined: none or minimal depression (0–6), mild depression (7–13), moderate depression (14–19), and severe depression (19–30). Nonetheless, clinical judgment supersedes EPDS scores. Therefore, a clinical assessment needs to be performed. The scale will not detect mothers with anxiety neuroses, phobias or personality disorders.

Scoring Guide

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

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

Please ensure that all items must be completed. Avoid the possibility of the mother discussing her answers with others. The mother should complete the scale independently, unless she has limited English or has difficulty with reading. Users may reproduce the scale as long as the authors are cited in all reproduced copies.

*Suggested cut-off score for screening fathers is 5-6 (Matthey et al., 2010). If the father's EDPS score falls within 5-6, consider making a referral to support services.

RECOMMENDED LANGUAGE WHEN INTRODUCING THE EPDS

> ***"Feeling depressed or anxious is very common among mothers during pregnancy and/or after birth, especially the ones we see in our clinic. 1 in 5 women experience depression, anxiety, or frightening thoughts during this time. The rates are even higher for mothers of preterm babies and babies with medical challenges. It is important that we screen for depression because of its impact on you and your baby's health. We will be seeing you and your baby a lot over the next few months/years and want to support you."***

CITATION
Modified from: Cox, J. L., Holden, J. M., & Sagovsky, R. (1987). Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. British Journal of Psychiatry, 150, 782-786. The Spanish version was developed at the University of Iowa based on earlier Spanish versions of the instrument. For further information, please contact Michael W. O'Hara, Department of Psychology, University of Iowa, Iowa City, IA 52245, e-mail: mikeohara@uiowa.edu.

Source: Adapted from Massachusetts Child Psychiatry Access Project for Moms' Postpartum Depression Screening Algorithm for Pediatric Providers During Well-Child Visits (mcpapformoms.org and DC Collaborative for Mental Health in Pediatric Primary Care Children's National Hospital

Implementing the Edinburgh Postnatal Depression Scale

1. After the EPDS has been distributed, collected, and scored - explain the screener:

> ***Feeling depressed or anxious is very common among mothers during pregnancy and/or after birth, especially the ones we see in our clinic. 1 in 5-7 women experience depression, anxiety, or frightening thoughts during this time. The rates are even higher for mothers of preterm babies and babies with medical challenges. It is important that we screen for depression because of its impact on you and your baby's health. We will be seeing you and your baby a lot over the next few months/years and want to support you.***

2. Explain the results and provide education specific to the woman's risk level (see page ____).

Below are recommendations and suggested language for discussing results in each range:

Score of 0-6: No or Minimal Depression

- Provide education about risks/incidence (Perinatal Mental Health Fact Sheet).
- Use clinical judgment regardless of the score.
- Provide Postpartum Support International contact for support groups and other community resources: 1.800.944.4773

> ***From the screen, it seems like you are doing well. Having a baby is always challenging and every parent deserves support. Do you have any concerns you would like to talk to us about? In the future, should you start to have a difficult time or develop depression or anxiety, please follow-up with your doctor or talk to me about it at your child's next visit.***

Score of 7-13: Moderate depression

- Discuss results and provide education (Perinatal Mental Health Fact Sheet).
- Strongly consider making a referral and/or providing Postpartum Support International number: 1.800.944.4773

> ***Based on your score, I am concerned that you may be having a difficult time or be depressed. It can be hard to feel this way when you have a baby/young child. There are things you can do to feel better. Let's talk about some ideas that might work for you.***

Scores of 14-19 Moderate Depression and above 20 and Severe Depression

- Discuss results and provide education (see Perniatal Mental Health Fact Sheet).
- Strongly consider making a referrals and/or providing Postpartum Support International number: 1.800.944.4773

> ***Based on your score, I am concerned that you may be having a difficult time or be depressed. It can be hard to feel this way when you have a baby/young child. There are things you can do to feel better. Let's talk about some ideas that might work for you.***

Question #10 (self-harm): If "Yes" to – hardly ever, sometimes, or quite often –

MOVE TO CRISIS ACTION PLAN

Source: Adapted from Massachusetts Child Psychiatry Access Project for Moms' Postpartum Depression Screening Algorithm for Pediatric Providers During Well-Child Visits, available at www.mcpapformoms.org and the DChealth

HOW ARE YOU DOING?

Edinburgh Postnatal Depression Scale

Name:_____ Your Date of Birth:_____

Your Baby's Date of Birth:_____ Phone Number:_____

Congratulations on your beautiful baby. This is such an exciting time in your life, and sometimes it can be overwhelming. We want toknow how you are doing. Please check the answer that comes closest to how you have felt. IN THE PAST 7 DAYS, not just how you feel today. Here is an example, already completed:

I have felt happy:

- o Yes, all the time
- ✓ Yes, most of the time
- o No, not very often
- o No, not at all

Please complete the other questions in the same way.

This would mean: "I have felt happy most of the time" during the past week.

1. I have been able to laugh and see the funny side of things

- o I always could
- o Not quite so much now
- o Definitely not so much now
- o Not at all

2. I have looked forward with enjoyment to things

- o As much as I ever did
- o Rather less than I used to
- o Definitely less than I used to
- o Hardly at all

3*. I have blamed myself unnecessarily when things went wrong

- o Yes, most of the time
- o Yes, some of the time
- o Not very often
- o No, never

4. I have been anxious or worried for no good reason

- o No, not at all
- o Hardly ever
- o Yes, sometimes
- o Yes, very often

5*. I have felt scared or panicky for no very good reason

- o Yes, quite a lot
- o Yes, sometimes
- o No, not much
- o No, not at all

* 6. Things have been getting on top of me

- o Yes, most of the time I haven't been able to cope at all
- o Yes, sometimes I haven't been coping as well as usual
- o No, most of the time I have coped quite well
- o No, I have been coping as well as ever

*7. I have been so unhappy that I have had difficulty sleeping

- o Yes, most of the time
- o Yes, sometimes
- o Not very often
- o No, not at all

* 8. I have felt sad or miserable

- o Yes, most of the time
- o Yes, sometimes
- o Not very often
- o No, not at all

*9. I have been so unhappy that I have been crying

- o Yes, most of the time
- o Yes, quite often
- o Only occasionally
- o No, never

*10. The thought of harming myself has occurred to me

- o Yes, quite often
- o Sometimes
- o Hardly ever
- o Never

Administered/Reviewed by_____ Date_____

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 .

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COMO ESTAS?

Escala Edinburgh para la Depresión Postnatal (EPDS)

Nombre: _____ Su fecha de Nacimiento:_____

Fecha de Nacimiento del Bebé:_____ Teléfono: _____

Como usted está embarazada o hace poco que tuvo un bebé, nos gustaría saber como se siente actualmente. Por favor MARQUE (√) la respuesta que más se acerca a como se ha sentido durante LOS ÚLTIMOS 7 DÍAS y no sólo como se ha sentido hoy.

Me he sentido feliz:

Por favor complete las otras preguntas de la misma manera

- o Me he sentido feliz:
- ✓ Sí, todo el tiempo
- o No, no muy a menudo
- o No, en absoluto

1. He podido reír y ver el lado bueno de las cosas
   - o Tanto como siempre he podido hacerlo
   - o No tanto ahora
   - o Sin duda, mucho menos ahora
   - o No, en absolute.

2. He mirado al futuro con placer para hacer cosas
   - o Tanto como siempre
   - o Algo menos de lo que solía hacerlo
   - o Definitivamente menos de lo que solía hacerlo
   - o Prácticamente nunca

3*. Me he culpado sin necesidad cuando las cosas marchaban mal
   - o Sí, casi siempre
   - o Sí algunas veces
   - o No Definitivamente menos de lo que solía hacerlo
   - o Prácticamente nunca

4. He estado ansiosa y preocupada sin motivo alguno
   - o No, en absoluto
   - o Casi nada
   - o Sí, a veces
   - o Sí, muy a menudo

5*. He sentido miedo o pánico sin motivo alguno
   - o No, en absoluto
   - o Casi nada
   - o Sí, a veces
   - o Sí, muy a menudo

* 6. Las cosas me oprimen o agobian
   - o Sí, la mayor parte del tiempo no he podido sobrellevarlas
   - o Sí, a veces no he podido sobrellevarlas de la manera
   - o No, la mayoría de las veces he podido sobrellevarlas bastante bien
   - o No, he podido sobrellevarlas tan bien como lo hecho siempre

*7. Me he sentido tan infeliz, que he tenido dificultad para dormir
   - o Sí, casi siempre
   - o Sí, a veces
   - o No muy a menudo
   - o No, en absolute

* 8. Me he sentido triste y desgraciada
   - o Sí, casi siempre
   - o Sí, bastante a menudo
   - o No muy a menudo
   - o No, en absolute

*9. Me he sentido tan infeliz que he estado llorando
   - o Sí, casi siempre
   - o Sí, bastante a menudo
   - o Ocasionalmente
   - o No, nunca

*10. He pensado en hacerme daño
   - o Sí, bastante a menudo
   - o A veces
   - o Casi nunca
   - o No, nunca

Administrada/Revisada por:_____ Fecha:_____

Fuente: Cox, J.L., Holden, J.M. y Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. Revista Británica de Psiquiatría 150:782-786.

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CRISIS ACTION PLAN

If the mother answered "YES" to #10 on EPDS or patient reports thoughts of harm to self or others, follow these steps

1. 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?"

2. If the mother has a plan and provider or patient feels she cannot be safe, follow these steps:

1. Do not leave patient by herself or alone with baby.
2. Contact and engage supportive person in their life (partner, relative, friend).
3. Make this person aware of current circumstance.
4. Engage them to plan for: child care, transportation to emergency services, emotional support.

3. Coordinate immediate psychiatric/crisis intervention or evaluation:

- Be familiar with Emergency Department policies and referral processes.
- When no resources are available, call 911 (ask for Crisis Intervention Officer/Team if available).
- Or call the National Suicide Prevention Lifeline at 800-273-8255.

4. If patient is not in the office and feels she cannot be safe or worries if she will be safe follow these steps:

1. Ask where she is and if she is alone .
2. Assess degree of risk.
3. Arrange for immediate psychiatric/crisis intervention or evaluation while patient remains on phone.
4. Assess availability and proximity of resources and support.

Assessing Thoughts of Harming Baby

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 the 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

Source: Adapted from Massachusetts Child Psychiatry Access Project for Moms' Postpartum Depression Screening Algorithm for Pediatric Providers During Well-Child Visits (mcpapformoms.org and DC Collaborative for Mental Health in Pediatric Primary Care Children's National Hospital

The *Perinatal* Depression Resources

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References

Agnafors, S., Sydsjo, G., & Go, C. (2013). Symptoms of depression postpartum and 12 years later-Associations to child mental health at 12 years of age. *Maternal and Child Health Journal*, 17(3), 405–414. https://doi.org/10.1007/s10995-012-0985-z

Alvarez, S., Meltzer-Brody, S., Mandel, M., & Beeber, L. (2015). Maternal depression and early intervention: A Call for an Integration of Services. Infants Young Child, 28(1), 72–87.

Balbierz, A., Bodnar-Deren, S., Wang, J. J., & Howell, E. A. (2015). Maternal depressive symptoms and parenting practices 3-Months postpartum. *Maternal and Child Health Journal*, 19(6), 1212-1219. https://doi.org/10.1007/s10995-014-1625-6

Byatt, N., Biebel, K., Cox, J., Chaudron, L., Ravech, M., & Straus, J. (2018). MCPAP for Moms: A Primer for Massachusetts pediatric providers. https://www.mcpapformoms.org/Docs/MCPAP for Moms Primer 3-14-18.pdf

Challacombe, F. L., Salkovskis, P. M., Woolgar, M., Wilkinson, E. L., Read, J., & Acheson, R. (2016). Parenting and mother-infant interactions in the context of maternal postpartum obsessive compulsive disorder: Effects of obsessional symptoms and mood. I*nfant Behavior and Development,* 44, 11–20. https://doi.org/10.1016/j.infbeh.2016.04.003

Clevesy, M. A., Gatlin, T. K., Cheese, C., & Strebel, K. (2019). A Project to improve postpartum depression screening practices among providers in a community women's health care clinic. *Nursing for Women's Health,* 23(1), 21–30. https://doi.org/10.1016/j.nwh.2018.11.005

Committee on Obstetric Practice. The American College of Obstetrics and Gynecology. (2018). Screening for perinatal depression. *Obstetrics & Gynecology*, 132(5), 208–212.

Earls, M. F., Yogman, M. W., Mattson, G., & Rafferty, J. (2019). Incorporating recognition and management of perinatal depression into pediatric practice. *Pediatrics,* 143(1). https://doi.org/10.1542/peds.2018-3259

Edward, K. leigh, Castle, D., Mills, C., Davis, L., & Casey, J. (2015). An integrative review of paternal depression. *American Journal of Men's Health*, 9(1), 26–34. https://doi.org/10.1177/1557988314526614

Fisher, S. (2017). Paternal mental health: Why is it relevant? *American Journal of Lifestyle Medicine*, 11(3), 200–211. DOI: 10.1177/1559827616629895

Ghaedrahmati, M., Kazemi, A., Kheirabadi, G., Bahrami, M., & Ebrahimi, A. (2018). Examining the relationship between mothers' prenatal mental health and demographic factors with postpartum depression. *Journal of Education and Health Promotion*, 7(146), 1–5. https://doi.org/10.4103/jehp.jehp

Gjerdingen, D. K., & Yawn, B. P. (2007). Postpartum depression screening: Importance, methods, barriers, and recommendations for practice. *Journal of the American Board of Family Medicine*, 20(3), 280–288. https://doi.org/10.3122/jabfm.2007.03.060171

Glasser, S. & Lerner-Geva, L. (2019). Focus on fathers: paternal depression in the perinatal period. *Perspectives in Public Health, 139*(4), 195-198. DOI: 10.1177/1757913918790597

Goodman, J.H. (2004). Paternal postpartum depression, its relationship to maternal postpartum depression, and implications for family health. Journal of Advanced Nursing. 45(1), 26–35. DOI:0.1046/j.1365-2648.2003.02857.x

Graham, I. D., Logan, J., Harrison, M. B., Straus, S. E., Tetroe, J., Caswell, W., & Robinson, N. (2006). Lost in knowledge translation: Time for a map? *The Journal of Continuing Education in the Health Professions,* 26(1), 13–24. http://pram.mcgill.ca/seminars/i/Graham_2006_Lost_in_Knowledge_Translation.pdf

Guttierez-Galve, L., Stein, A., Hanington, L., Heron, J., & Ramchandani, P. (2015). Paternal depression in the postnatal period and child development: Mediators and moderators. *Pediatrics, 1*35(2), e339–e347. DOI: 10.1542/peds.2014-2411

Gutierrez-Galve, L., Stein, A., Hanington, L., Heron, J., Lewis, G., O'Farrelly, C., Ramchandani, P.G., (2019). Association of maternal and paternal depression in the postnatal period with offspring depression at age 18 years. JAMA *Psychiatry* 76(3), 290–296. DOI: 10.1001/jamapsychiatry.2018.3667

Isacco, A., Hofscher, R., & Molloy, S. (2016). An examination of fathers' mental health help-seeking: A brief report. *American Journal of Men's Health*, 10(6), n33-n38. DOI: 10.1177/1557988315581395

Keating-Lefler, R., & Wilson, M. E. (2004). The experience of becoming a mother for single, unpartnered, Medicaid-eligible, first-time mothers. J*ournal of Nursing Scholarship*, 36(1), 23–29. https://doi.org/10.1111/j.1547-5069.2004.04007.x

Kothari, C. L., Liepman, M. R., Tareen, R. S., Florian, P., Charoth, R. M., Haas, S., Mckean, J. W., Moe, A., Wiley, J., & Curtis, A. (2016). Intimate partner violence associated with postpartum depression, regardless of socioeconomic status. *Maternal and Child Health Journal,* 20(6), 1244–1253. https://doi.org/10.1007/s10995-016-1925-0

Liu, C. H., & Tronick, E. (2013). Rates and predictors of postpartum depression by race and ethnicity: Results from the 2004 to 2007 New York city PRAMS survey (pregnancy risk assessmentmonitoring system). Maternal and *Child Health Journal,* 17(9), 1599–1610. https://doi.org/10.1007/s10995-012-1171-z

Luca, D. L., Margiotta, C., Staatz, C., Garlow, E., Christensen, A., & Zivin, K. (2020). Financial toll of untreated perinatal mood and anxiety Ddsorders among 2017 Births in the United States. *American Journal of Public Health,* 110(6), 888–896. https://doi.org/10.2105/AJPH.2020.305619

Matthey, S., Barnett, B., Kavanagh, D. J., & Howie, P. (2001). Validation of the Edinburgh Postnatal Depression Scale for men, and comparison of item endorsement with their partners. *Journal of Affective Disorders*, *64*(2–3), 175–184. https://doi.org/10.1016/S0165-0327(00)00236-6

Olson, A. L., Dietrich, A. J., Prazar, G., & Hurley, J. (2006). Brief maternal depression screening at well-child visits. *Pediatrics*, 118(1), 207–216. https://doi.org/10.1542/peds.2005-2346

Oliffe, J.L. & Phillips, M.J. (2008). Men, depression, and masculinities: A review and recommendations. *Journal of Men's Health*, 5(3), 194-202. DOI: 10.1016/j.jomh.2008.03.016

Pao, C., Guintivano, J., Santos, H., & Meltzer-Brody, S. (2019). Postpartum depression and social support in a racially and ethnically diverse population of women. *Archives of Women's Mental Health*, 22(1), 105–114. https://doi.org/10.1007/s00737-018-0882-6

Paulson, J.F., Bazemore, S.D., (2010). Prenatal and postpartum depression in fathers and its association with maternal depression: a meta-analysis. *JAMA*, 303(19), 1961–1969. DOI: 10.1001/jama.2010.605

Segre, L. S., Losch, M. E., & O'Hara, M. W. (2006). Race/ethnicity and perinatal depressed mood. *Journal of Reproductive and Infant Psychology*, 24(2), 99–106. https://doi.org/10.1080/02646830600643908

Sherman, L. J., & Ali, M. M. (2018). Diagnosis of postpartum depression and timing and types of treatment received differ for women with private and Medicaid coverage. *Women's HealthIssue*s, 28(6), 524–529. https://doi.org/10.1016/j.whi.2018.08.007

Silverman, M. E., Reichenberg, A., Savitz, D. A., Cnnattingus, S., Lichenstein, P., Hultman, C., Larrson, H., & Sandin, S. (2017). The risk factors for postpartum deppesion: A population based study. *Depression and Anxiety*, 34(2), 178–187. https://doi.org/doi:10.1002/da.22597

Singley, D. & Edwards, L. (2015). Men's perinatal mental health in the transition to fatherhood. Professional Psychology: *Research and Practice,* 46(5), 309–316. DOI: 10.1037/pro0000032

Sui, A. L., & US Preventative Services Task Force. (2016). Screening for depression in adults US Preventive Services Task Force recommendation statement. *JAMA* (Vol. 315, Issue 4). https://doi.org/10.1001/jama.2015.18392

Tahirkheli, N. N., Cherry, A. S., Tackett, A. P., McCaffree, M. A., & Gillaspy, S. R. (2014). Postpartum depression on the neonatal intensive care unit: Current perspectives. *International Journal of Women's Health,* 6, 975–987. https://doi.org/10.2147/IJWH.S54666

Van Der Zee-Van Den Berg, A. I., Boere-Boonekamp, M. M., Groothuis-Oudshoorn, C. G. M., IJzerman, M. J., Haasnoot-Smallegange, R. M. E., & Reijneveld, S. A. (2017). Post-up study: Postpartum depression screening in well-child care and maternal outcomes. *Pediatrics,* 140(4). https://doi.org/10.1542/peds.2017-0110

Vigod, S. N., Villegas, L., Dennis, C. L., & Ross, L. E. (2010). Prevalence and risk factors for postpartum depression among women with preterm and low-birth-weight infants: A systematic review. *BJOG: An International Journal of Obstetrics and Gynaecology*, 117(5), 540–550. https://doi.org/10.1111/j.1471-0528.2009.02493.x

Wachino, V. (2016). Maternal depression screening and treatment: A critical role for Medicaid in the care of mothers and children. https://www.medicaid.gov/sites/default/files/Federal-Policy Guidance/Downloads/cib051116.pdf

Wisner, K. L., Sit, D. K. Y., McShea, M. C., Rizzo, D. M., Zoretich, R. A., Hughes, C. L., Eng, H. F., Luther, J. F., Wisniewski, S. R., Costantino, M. L., Confer, A. L., Moses-Kolko, E. L., Famy, C. S., & Hanusa, B. H. (2013). Onset timing, thoughts of self-harm, and diagnoses in postpartum women with screen-positive depression findings. *JAMA Psychiatry*, 70(5), 490–498. https://doi.org/10.1001/jamapsychiatry.2013.87

Postpartum Depression Screening Toolkit