### Management of Perinatal Mood Disorders During Pregnancy

### Overview:

Healthcare providers play an integral role in identifying and managing (i.e. treating or referring to care) perinatal mood disorders among pregnant women. This training is designed to provide an overview of the harmful effects of depression and anxiety on numerous maternal and child outcome, as well as enhance patient-provider communication using a 5As framework (i.e.

Assess, Advise, Agree, Assist and Arrange) to teach providers how to assess for depression and anxiety, advise the patient on treatment options, agree on a treatment plan, assist patient in any problem solving related to obtaining treatment, and arrange for supports for the patient. communicate the current national guidelines, safety and counseling strategies related to perinatal mood disorders.

### Target Audience:

The intended audience for this activity is for health care practitioners providing obstetric care.

### Copyright Statement:

Created and published by the University of Colorado Denver, Colorado School of Public Health. Printed in the USA; Copyright 2011 University of Colorado Denver. All rights reserved. No part of this publication may be reproduced without written permission from the publisher. The material presented at or in any of the University of Colorado Denver does not necessarily reflect the views and opinions of the University of Colorado Denver. The University of Colorado Denver nor the faculty endorse or recommend any techniques, commercial products, or manufactures.

### Learning Objectives:

Upon successful completion of this activity, participants will be able to:

* Identify current guidelines for prenatal depression and anxiety assessment and treatment
* Locate and utilize screening assessment tools for perinatal mood disorders
* Develop knowledge on available evidence-based treatments for prenatal mood disorders
* Develop skills to increase self-efficacy and intent to manage prenatal mood disorders
* Locate local and national resources for perinatal mood disorders.

***Identifying and Managing Anxiety and Depression during Pregnancy***

***Introduction***

Many women experience depression during pregnancy with prevalence estimates ranging from 12% for major depressive disorder up to 51% for minor depressive disorder.[i](#_bookmark0) Antenatal depression has been associated with pregnancy complications,[ii](#_bookmark1) increased medical care,[iii](#_bookmark2) and compromised fetal and child outcomes[.iv](#_bookmark3)[,v](#_bookmark4)[,vi](#_bookmark5) Antenatal depression is also linked to postnatal depression,[vii](#_bookmark6) underscoring the importance of identifying and treating antenatal depression.

Moreover, past studies suggest that the interaction between the chronicity and severity of maternal depressive symptomatology increases the risk of her offspring developing behavioral and learning problems later.[viii](#_bookmark7) Clearly there is a need to identify and treat antenatal depression.

Healthcare providers play a significant role in helping to identify and manage (e.g. treat and/or refer) antenatal depression. Often healthcare providers are the sole exposure to mental health resources for women. Being able to 1) identify women who are exhibiting depressive and anxiety symptomatology, 2) provide guidance based on evidence-based practices, 3) utilize linkages to mental health specialists and 4) understand ways to enhance patient-provider communication are all integral in providing optimal patient-centered care related to perinatal mood disorders (i.e. anxiety and depression).

The following module will provide an overview of the harmful effects of depression and anxiety on numerous maternal and child outcomes, as well as provide a framework using the 5As model (i.e. Assess, Advise, Agree, Assist and Arrange) to teach providers how to assess for depression and anxiety, advise the patient on treatment options, agree on a treatment plan, assist patient in any problem solving related to obtaining treatment, and arrange for supports for the patient.

Please see Figure 1 below.

**5As MODEL for Patient-Provider Communication – Depression & Anxiety**

**Step 1:**

Assess

**Stage 2:**

Advise

**Step 3:**

Agree

**Step 4 &5:**

Assist & Arrange

Assess patient symptomatology

Assist

Administer Screening Tool

Discuss various treatment plans with patient

Agree on Treatment Plan

and

A

rrange

Follow-up Assessment

for follow up support

***Harmful Effects of Untreated Anxiety and Depression During Pregnancy***

# Depression

Untreated maternal depression can impact mothers and their babies in a variety of ways. Often, women with depression may have a hard time caring for themselves during pregnancy. They may:

* Eat poorly
* Not gain enough weight
* Have trouble sleeping
* Miss prenatal visits
* Not follow medical instructions
* Use harmful substances like tobacco, alcohol, or drugs[.ix](#_bookmark8)

Mothers experiencing depression may experience pre-term deliveries or other problems during pregnancy or delivery such as low birth weight and greater need for intervention during delivery. Additionally, maternal depression impacts maternal-infant interaction with greater likelihood of irritability, less activity and attentiveness, and fewer facial expressions compared to nondepressed mother-infant interactions.[x](#_bookmark9) Maternal depression can also have negative effects on children, causing delays in language development, challenges with mother-child bonding, behavior problems, and increased crying.[xi](#_bookmark10)

# Anxiety

Untreated anxiety during pregnancy may also have negative impacts on mothers and their infants. Mothers may be affected by state and trait anxiety, but may also experience pregnancy- specific anxiety which been linked with negative health outcomes for women and their babies. While it is similar to state anxiety, pregnancy anxiety is a distinct condition, and can be defined as “fears about the health and well-being of one’s baby, impending childbirth, of hospital and health care experiences, birth and postpartum, and of parenting the material role.”[xii](#_bookmark11)

Anxiety during pregnancy has been associated with the following negative effects:[xii](#_bookmark11)[i](#_bookmark12)[,](#_bookmark11)[xiv](#_bookmark12)[,xv](#_bookmark13)

* Increased uterine artery resistance causing reduced blood flow to the fetus
* Pre-term birth and low birth weight
* Lower Apgar scores at birth
* Increased risk of postpartum depression in mothers with prenatal anxiety
* Colic and difficult temperament during infancy, as well as behavior problems at 4 years
* Decreased gray matter density in children

***STAGE 1 – ASSESS: Identifying Anxiety and Depressive Symptoms***

Pregnant women experiencing depression and/or anxiety may experience different types of symptoms. Often the symptoms of depression are ignored or misdiagnosed because many pregnancy symptoms such as fatigue, weight change, and other bodily symptoms, mimic the symptoms of depression.[xvi](#_bookmark13) Because depression symptoms can be similar to pregnancy

symptoms, additional information gathering and screening is important. As a healthcare provider, the first step is to ASSESS your patient’s current depressive and anxiety symptomatology. By asking open-ended questions, you can obtain information from your patient and help identify women who may have depression and/or anxiety. Below are examples of questions and symptoms that are not intended to provide a clinical diagnosis; but can help a provider know if additional screening and diagnosis may be necessary.

### Assess Patient Symptomatology

Providers may use the following questions to learn more from patients that they suspect may be depressed:

* + “How’s your mood been lately?”
	+ “How are things at home/work?”
	+ “How’s your concentration?”
	+ “Have you been feeling down on yourself?”
	+ “What have you enjoyed doing lately?”
	+ “How have you been sleeping?”
	+ “What about your appetite?”
	+ “How’s your energy?”[xvii](#_bookmark14)

When providers ask these questions, they may listen for certain symptoms. Symptoms may appear during pregnancy, after birth, or within the first year after giving birth. Common depressive symptoms include:

* + Sad or depressed mood
	+ Loss of interest or pleasure in activities person used to enjoy
	+ Weight loss when not dieting or weight gain
	+ Decrease or increase in appetite
	+ Trouble sleeping or sleeping too much
	+ Moving more slowly or moving more quickly than usual
	+ Fatigue or loss of energy
	+ Feelings of worthlessness or guilt
	+ Having trouble thinking, concentrating, or making decisions
	+ Thoughts of death or suicidexviii

Common anxiety symptoms 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[xix](#_bookmark15)

### Administer Screening Tool

If patients describe the symptoms above in a conversation with their provider, providers may use the screening tools described later in this guide to more formally screen for depression and

anxiety. Screening for perinatal depression and anxiety is important because the conditions if left untreated can have harmful effects on the mother, the developing fetus, and the child’s later development.

### Follow-up Assessment

Screening tools help identify patients who may be at greater risk for depression and/or anxiety. If patients screen positive, a follow-up diagnosis should be made based on the DSM-V criteria.

These criteria for a major depressive disorder or a major depressive episode are stated below:

* + ç
		- Depressed mood most of the day, almost every day
		- Diminished interest or pleasure in all or most activities most of the day, almost every day
		- Significant unintentional weight loss or gain or change in appetite almost every day
		- Insomnia or sleeping too much almost every day
		- Agitation or slowing of physical or mental activity noticed by others almost every day
		- Fatigue or loss of energy almost every day
		- Feelings of worthlessness or excessive guilt almost every day
		- Decreased ability to think or concentrate, or indecisiveness almost every day
		- Recurrent thoughts of death, suicidal ideation, a suicide attempt, or a specific plan for committing suicide
	+ The symptoms cause clinically significant distress or impairment in social, occupational, or other areas of functioning
	+ The symptoms are not due to the effects of a substance or another medical condition
	+ The occurrence of a major depressive episode is not better explained by another psychotic disorder such as schizophrenia or other disorders
	+ The patient has never experienced a manic or hypomanic episode[xx](#_bookmark16)

The DSM V criteria for Generalized Anxiety Disorder are as follows:

* + The presence of excessive anxiety and worry about a variety of topics, events, or activities. Worry occurs more often than not for at least 6 months and is clearly excessive.
	+ The anxiety and worry is associated with at least 3 of the following [physical](https://www.verywell.com/what-does-anxiety-feel-like-6-physical-symptoms-1393151) or cognitive symptoms:
		- Edginess or restlessness.
		- Tiring easily; more fatigued than usual.
		- Impaired concentration or feeling as though the mind goes blank.
		- Irritability (which may or may not be observable to others).
		- Increased muscle aches or soreness.
		- Difficulty sleeping (due to trouble falling asleep or staying asleep, restlessness at night, or unsatisfying sleep).
	+ The anxiety, worry, or associated symptoms make it hard to carry out day-to-day activities and responsibilities. They may cause [problems in relationships,](https://www.verywell.com/how-anxiety-can-cause-relationship-problems-1393090) at work, or in other important areas.
	+ These symptoms are unrelated to any other medical conditions and cannot be explained by the effect of substances including a prescription medication, alcohol or recreational drugs.
	+ These symptoms are not better explained by a different mental disorder. [xxi](#_bookmark17)

***Guidelines for Anxiety and Depression Screening and Treatment During Pregnancy***

American College of Nurse Midwives (ACNM): Position Statement- Mental Health During Childbirth and Across the Lifespan (as of October 2020 and replacing “Depression in Women” Policy Statement of 2013) <https://www.midwife.org/acnm/files/acnmlibrarydata/uploadfilename/000000000324/PS-Mental%20Health%20During%20Childbirth%20and%20Across%20Lifespan.pdf>

* ACNM recommends “all people receiving midwifery care should be assessed for depression and other mental health disorders during routine visits.”
* ACNM suggests health care providers “should educate clients on how to recognize symptoms of mental health disorders, access more information, and seek treatment.”
* ACNM recommends that “all perinatal clients should be evaluated for depression and other mental health disorders at least twice during pregnancy and at regular intervals postpartum.”
* ACNM suggests every midwifery practice “should have a systematic response to a positive screen or risk assessment, including knowledge of treatment modalities and referral to trained mental health providers.”

American Academy of Family Physicians (AAFP):

Siu AL, and the US Preventive Services Task Force (USPSTF). Screening for Depression in Adults: US Preventive Services Task Force Recommendation Statement. *JAMA.* 2016;315(4):380–387. doi:10.1001/jama.2015.18392 https://jamanetwork.com/journals/jama/fullarticle/2484345#:~:text=The%20American%20Academy%20of%20Family,%2C%20and%20appropriate%20follow%2Dup.

(link to 2010 recs was broken)

* The American Academy of Family Physicians recommends “screening for depression in the general adult population, including pregnant and postpartum women.”
* According to AAFP, “screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.”

American College of Obstetricians and Gynecologists (ACOG): Treatment and Management of Mental Health Conditions During Pregnancy and Postpartum 2023 <https://www.acog.org/clinical/clinical-guidance/clinical-practice-guideline/articles/2023/06/treatment-and-management-of-mental-health-conditions-during-pregnancy-and-postpartum>

* ACOG recommends “that obstetricians be prepared to counsel patients on the benefits and risks of psychopharmacotherapy for perinatal mental health conditions when clinically indicated.”
* ACOG recommends “that obstetricians initiate psychopharmacotherapy for perinatal depression or anxiety disorders, refer patients to appropriate behavioral health resources when indicated, or both.”
* ACOG recommends “that treatment for perinatal mood and anxiety disorders be equitably available and accessible to all pregnant and postpartum individuals.”
* ACOG suggests to “use Perinatal Psychiatry Access Programs as a resource for management and treatment guidance for individuals with mental health conditions.”

American Psychological Association (APA):

APA’s “Position Statement on Screening and Treatment of Mood and Anxiety Disorders During Pregnancy and Postpartum” 2019 strongly recommends the following actions:

<https://psychnews.psychiatryonline.org/doi/full/10.1176/appi.pn.2019.3b19#:~:text=More%20serious%20mental%20health%20problems,women%20from%20lower%20socioeconomic%20backgrounds>.

* The APA recommends “assessing all pregnant and postpartum women for the presence of—and risk factors for—a psychiatric disorder.”
* The APA recommends “educating perinatal women on how to recognize the symptoms of depressive, anxiety, and psychotic disorders.”
* The APA recommends “screening pregnant women with a validated screening tool twice during pregnancy and again during pediatric visits throughout the first six months postpartum. Physicians should also put in place a systematic response to ensure that psychiatric disorders are appropriately assessed, treated, and followed.”
* The APA recommends “educating patients about the risks posed by untreated psychiatric illness during pregnancy and lactation, as well as the risks and benefits for both the woman and her baby of using psychotropic medications while pregnant or breastfeeding.”

***Screening Tools for Anxiety and Depression During Pregnancy***

Many tools exist for providers to assess their patients’ depression and anxiety. The tools below

have been used in a variety of populations, including women in the perinatal period.

# Common Anxiety Scales:

|  |  |  |  |
| --- | --- | --- | --- |
| **Screening Tool** | **Survey Details** | **Scoring** | **Learn More** |
| **Generalized Anxiety Disorder** (GAD – 7) | Administered by provider interview or by patient self-report7 itemsTakes less than 5 minutes to complete | Score range from 0-21Each item is scored from 0 to 3 (0=not at all; 3=nearly every day) and scores are totaled.Score of 10 or higherindicates generalized anxiety disorder | Spitzer, R.L., Kroenke, K., Williams, J.W., and Lowe, B. (2006). A brief measure for assessing generalized anxiety disorder: The GAD-7. *Archives of Internal Medicine, 166*, 1092 –1097.Sensitivity: 89%Specificity: 82% |
| [https://www.hiv.u](https://www.hiv.uw.edu/page/mental-health-screening/gad-7) [w.edu/page/ment](https://www.hiv.uw.edu/page/mental-health-screening/gad-7) [al-health-](https://www.hiv.uw.edu/page/mental-health-screening/gad-7) [screening/gad-7](https://www.hiv.uw.edu/page/mental-health-screening/gad-7) |
| **PRIME MD 2A**(GAD-2) | Administered by provider interview or by patient self-report | Scores range from 0-3Each item is scored from 0 to 3 (0=not at all; 3=nearly every day) and scores are totaled.Score of 3 or higher indicates possible generalized anxiety disorder | Kroenke, K., Spitzer, R.L., Williams, J.B.W., Monahan, P.O., and Lowe, B. (2007). Anxiety disorders in primary care: prevalence, impairment, comorbidity, and detection. *Annals of Internal Medicine, 146*, 317 –325.Sensitivity: 88% for GAD Specificity: 81-83%[xxvi](#_bookmark21) |
| [https://www.hiv.u](https://www.hiv.uw.edu/page/mental-health-screening/gad-2) [w.edu/page/ment](https://www.hiv.uw.edu/page/mental-health-screening/gad-2) [al-health-](https://www.hiv.uw.edu/page/mental-health-screening/gad-2) [screening/gad-2](https://www.hiv.uw.edu/page/mental-health-screening/gad-2) |
| **State-Trait Anxiety Inventory\*** (STAI) | Administered by provider interview or by patient self-report40 items (20 for state anxiety scale, 20 for train anxiety scale) | Scores range from 20-80 for each sub-testCut point of 39-40 detects clinically significant symptoms of State anxiety | Spielberger, C.D., Gorsuch, R.L., Lushene, R., Vagg, P.R., and Jacobs, G.A. (1983). *Manual for the State-Trait Anxiety Inventory.* Palo Alto, CA: Consulting Psychologists Press. |
| Takes approximately 10 minutes to complete | Each item is scored from 1(not at all) to 4 (very much so) for S-scale and from 1 (almost never) to 4 (almost always) for T scale. Anxiety-absentitems should be reverse- scored. | Can be purchasedfrom: [http://www.mindgarden.com/](http://www.mindgarden.com/products/staisad.htm#ms) [products/staisad.htm#ms](http://www.mindgarden.com/products/staisad.htm#ms) |
| **Beck Anxiety Inventory\*** (BAI) | Administered by self- report or by interviewer21 items | Scores range from 0-63:* 0-9, normal or no anxiety
* 10-18, mild to moderate anxiety
* 19-29, moderate to severe anxiety
* 30-62, severe anxiety
 | Beck, A.T., Epstein, N., Brown, G., and Steer, R.A. (1988). An inventory for measuring clinical anxiety: Psychometric properties.*Journal of Consulting and Clinical Psychology, 56*(6), 893 – 897. |
| Takes 5-10 minutes to complete | Sensitivity: 0.70Specificity: 0.74xxvii (in community mental health settings, at a cut- point of 12) |

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  | Can be purchasedfrom: [http://www.pearsonclinical.c](http://www.pearsonclinical.com/psychology/products/100000251/beck-anxiety-inventory-bai.html?Pid=015-8018-400) [om/psychology/products/10000025](http://www.pearsonclinical.com/psychology/products/100000251/beck-anxiety-inventory-bai.html?Pid=015-8018-400) [1/beck-anxiety-inventory-](http://www.pearsonclinical.com/psychology/products/100000251/beck-anxiety-inventory-bai.html?Pid=015-8018-400) [bai.html?Pid=015-8018-400](http://www.pearsonclinical.com/psychology/products/100000251/beck-anxiety-inventory-bai.html?Pid=015-8018-400) |

\*Scale is not free to use

# Common Depression Scales:

|  |  |  |  |
| --- | --- | --- | --- |
| **Screening Tool** | **Survey Details** | **Scoring** | **Learn More** |
| **Edinburgh Postnatal Depression Scale** (EPDS)[https://med.stanfo](https://med.stanford.edu/content/dam/sm/ppc/documents/DBP/EDPS_text_added.pdf) | Administered by self- report10 items | Score range 0-30Questions 1, 2, and 4, arescored 0, 1, 2, 3, with the top box as 0 and the bottom box as 3.Questions 3 and 5-10 are reverse scored, with the top box scored as 3 and the bottom box scored as 0,Score of 12 or higher may indicate depression | 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.Sensitivity: 86%Specificity: 78% |
| [rd.edu/content/da](https://med.stanford.edu/content/dam/sm/ppc/documents/DBP/EDPS_text_added.pdf) |
| [m/sm/ppc/docum](https://med.stanford.edu/content/dam/sm/ppc/documents/DBP/EDPS_text_added.pdf) [ents/DBP/EDPS\_](https://med.stanford.edu/content/dam/sm/ppc/documents/DBP/EDPS_text_added.pdf) |
| [text\_added.pdf](https://med.stanford.edu/content/dam/sm/ppc/documents/DBP/EDPS_text_added.pdf) |
| **Patient Health Questionnaire** (PHQ-9)[https://med.stanfo](https://med.stanford.edu/fastlab/research/imapp/msrs/_jcr_content/main/accordion/accordion_content3/download_256324296/file.res/PHQ9%20id%20date%2008.03.pdf) | Administered by self- report9 itemsTakes less than 5 minutes to complete | Score range 0-27Each item is scored from 0 to 3 (0=not at all; 3=nearly every day) and scores are totaled.Score of 10 or higher may indicate depression | Kroenke, K., Spitzer, R.L., and Williams, J.B. (2001). The PHQ-9: Validity of a brief depression severity measure. *Journal of General Internal Medicine, 16*, 606-613.Sensitivity: 88%Specificity: 88% |
| [rd.edu/fastlab/res](https://med.stanford.edu/fastlab/research/imapp/msrs/_jcr_content/main/accordion/accordion_content3/download_256324296/file.res/PHQ9%20id%20date%2008.03.pdf) [earch/imapp/msrs](https://med.stanford.edu/fastlab/research/imapp/msrs/_jcr_content/main/accordion/accordion_content3/download_256324296/file.res/PHQ9%20id%20date%2008.03.pdf) |
| [/\_jcr\_content/mai](https://med.stanford.edu/fastlab/research/imapp/msrs/_jcr_content/main/accordion/accordion_content3/download_256324296/file.res/PHQ9%20id%20date%2008.03.pdf)[n/accordion/accor](https://med.stanford.edu/fastlab/research/imapp/msrs/_jcr_content/main/accordion/accordion_content3/download_256324296/file.res/PHQ9%20id%20date%2008.03.pdf) |
| [dion\_content3/do](https://med.stanford.edu/fastlab/research/imapp/msrs/_jcr_content/main/accordion/accordion_content3/download_256324296/file.res/PHQ9%20id%20date%2008.03.pdf) [wnload\_2563242](https://med.stanford.edu/fastlab/research/imapp/msrs/_jcr_content/main/accordion/accordion_content3/download_256324296/file.res/PHQ9%20id%20date%2008.03.pdf) [96/file.res/PHQ9](https://med.stanford.edu/fastlab/research/imapp/msrs/_jcr_content/main/accordion/accordion_content3/download_256324296/file.res/PHQ9%20id%20date%2008.03.pdf)[%20id%20date%](https://med.stanford.edu/fastlab/research/imapp/msrs/_jcr_content/main/accordion/accordion_content3/download_256324296/file.res/PHQ9%20id%20date%2008.03.pdf) [2008.03.pdf](https://med.stanford.edu/fastlab/research/imapp/msrs/_jcr_content/main/accordion/accordion_content3/download_256324296/file.res/PHQ9%20id%20date%2008.03.pdf) |
| **Patient Health Questionnaire – 2** (PHQ-2)[https://www.hiv.](https://www.hiv.uw.edu/page/mental-health-screening/phq-2) [uw.edu/page/me](https://www.hiv.uw.edu/page/mental-health-screening/phq-2) [ntal-health-](https://www.hiv.uw.edu/page/mental-health-screening/phq-2) [screening/phq-2](https://www.hiv.uw.edu/page/mental-health-screening/phq-2) | Administered by self- report2 items | Score range from 0-6Each item is scored from 0 to 3 (0=not at all; 3=nearly every day) and scores are totaled. | Kroenke, K., Spitzer, R.L., and Williams, J.B. (2003). The Patient Health Questionnaire – 2: Validity of a two-item depression screener. *Medical Care, 41*(11), 1284 –1292. |
| Score of 3 or higher may indicate depression. | Sensitivity: 83%Specificity: 82% |

|  |  |  |  |
| --- | --- | --- | --- |
| **Center for Epidemiologic Studies – Depression** (CES-D)[http://www.brightf](http://www.brightfutures.org/mentalhealth/pdf/professionals/bridges/ces_dc.pdf) [utures.org/mentalh](http://www.brightfutures.org/mentalhealth/pdf/professionals/bridges/ces_dc.pdf) [ealth/pdf/professio](http://www.brightfutures.org/mentalhealth/pdf/professionals/bridges/ces_dc.pdf) [nals/bridges/ces\_d](http://www.brightfutures.org/mentalhealth/pdf/professionals/bridges/ces_dc.pdf)[c.pdf](http://www.brightfutures.org/mentalhealth/pdf/professionals/bridges/ces_dc.pdf) | Administered by provider interview or self-report20 itemsTakes 10 minutes to complete | Score range 0-60Each item scored 0, 1, 2, 3 (0=rarely, 3=most of the time), except for items 4, 8, 12, and 16, which are reverse scored (rarely=3, most of the time=0). | Radloff, L.S. (1977). The CES-DScale: a self-report depression scale for research in the general population. *Applied Psychological Measurement, 1*, 385 – 401.Sensitivity: 60%Specificity: 92% |

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | Score of 16 or higher isthe cut-point for depression |  |
| **Beck Depression** **Inventory II\*** (BDI-II)[http://www.pearso](http://www.pearsonclinical.com/psychology/products/100000159/beck-depression-inventoryii-bdi-ii.html?Pid=015-8018-370&amp%3BMode=summary) [nclinical.com/psyc](http://www.pearsonclinical.com/psychology/products/100000159/beck-depression-inventoryii-bdi-ii.html?Pid=015-8018-370&amp%3BMode=summary) [hology/products/10](http://www.pearsonclinical.com/psychology/products/100000159/beck-depression-inventoryii-bdi-ii.html?Pid=015-8018-370&amp%3BMode=summary) [0000159/beck-](http://www.pearsonclinical.com/psychology/products/100000159/beck-depression-inventoryii-bdi-ii.html?Pid=015-8018-370&amp%3BMode=summary) [depression-](http://www.pearsonclinical.com/psychology/products/100000159/beck-depression-inventoryii-bdi-ii.html?Pid=015-8018-370&amp%3BMode=summary) [inventoryii-bdi-](http://www.pearsonclinical.com/psychology/products/100000159/beck-depression-inventoryii-bdi-ii.html?Pid=015-8018-370&amp%3BMode=summary) [ii.html?Pid=015-](http://www.pearsonclinical.com/psychology/products/100000159/beck-depression-inventoryii-bdi-ii.html?Pid=015-8018-370&amp%3BMode=summary) [8018-](http://www.pearsonclinical.com/psychology/products/100000159/beck-depression-inventoryii-bdi-ii.html?Pid=015-8018-370&amp%3BMode=summary)[370&Mode=summ](http://www.pearsonclinical.com/psychology/products/100000159/beck-depression-inventoryii-bdi-ii.html?Pid=015-8018-370&amp%3BMode=summary) [ary](http://www.pearsonclinical.com/psychology/products/100000159/beck-depression-inventoryii-bdi-ii.html?Pid=015-8018-370&amp%3BMode=summary) | 21 itemsTakes 5-10 minutes to complete | Each item is rated from 0- 3 and the scores are summed.Score range from 0-63Score of 18 or gather indicates possible depression. | Beck, A.T., Steer, R.A., and Brown, G.K. (1996). *Manual for the Beck Depression Inventory – II*. San Antonio, TX: Psychological Corporation.Sensitivity: 56 – 75%Specificity: 97 – 100% |
| **Postpartum Depression Screening Scale\*** (PDSS) | Administered by patient self-report35 itemsTakes 5-10 minutes to complete | Patients rank statements from strongly disagree (1) to strongly agree (5). Total score ranges between 35 and 175.Score of 80 and higher indicates depression | Beck, C.T., and Gable, R.K. (2000). Postpartum Depression Screening Scale: Development and psychometric testing. *Nursing Research, 49*, 272-282.Sensitivity: 94%Specificity: 98% |

\*Scale is not free to use.

***STAGES 2 & 3: ADVISE AND AGREE - Management of Depression During Pregnancy***

If a patient screens positive for depression and anxiety, further evaluation should be conducted to diagnose possible mood disorder using the DSM-V criteria. If a provider determines that a patient is experiencing depression or anxiety, the patient and provider should work together to evaluate the benefits, risks, and options for different treatments. The effects of depression or anxiety on the patient and on her fetus must be considered when recommending treatment. The choice of treatment depends on the seriousness of the patient’s condition, the patient’s needs and preferences, and the availability of mental health or psychiatric services in the local community.xxviii The provider should advise patients on various treatment options (and the impact of not treating) and work with the patient to develop a treatment plan that works.

# Treatment Options

Several options exist for pregnant women with depression. Psychotherapy has been used successfully to treat depression both in women who are pregnant and in the general population. Counseling may be used alone or in conjunction with medication, and should be provided by a qualified mental health professional. Pharmacological treatments are also an option. Finally, several alternative therapies for treating anxiety and depression are described below. Providers may opt to treat patients in-house, or may refer them to an outside mental health provider.

***Psychotherapy***

### Interpersonal Therapy (IPT)

IPT targets social functioning, with emphasis on interpersonal disputes, role transitions, grief, and interpersonal deficits.[xxix](#_bookmark22) IPT is based on the observation that major depression often occurs in an interpersonal context, often after an interpersonal loss or dispute. It consists of weekly psychotherapy sessions that are usually conducted for 12 – 16 weeks, although it can be used for longer to maintain treatment gains. The focus of IPT is on improving the quality of the patient’s interpersonal functioning.[xxx](#_bookmark23) A review by Dimidjian and Goodman (2009) and a meta-analysis by Sockol, et. al. (2011) both found that evidence supports the effectiveness of IPT as a treatment for depression during pregnancy and in the postpartum period.

The following are examples of evidence for the effectiveness of IPT in treating antenatal depression:

* Spinelli et. al. (2003) conducted a 16-week randomized control trial of an IPT intervention compared to a parent education intervention and found that patients who received IPT had significantly greater and more rapid change in depression during the antenatal period than those who received parent education.[xxxi](#_bookmark24)
* Grote, et. al. (2009) conducted a randomized control trial of an enhanced IPT (IPT-B) designed to treat perinatal depression compared with enhanced usual care, and found that the patients in IPT-B showed significant reductions in depression diagnoses and symptoms before childbirth and at six months postpartum.xxxii

Additional evidence exists documenting the positive results from treating postpartum depression with IPT:

* O’Hara et. al. (2000) conducted a randomized control trial in which women who met the DSM-IV diagnostic criteria for major depression received 12 weeks of IPC or a waitlist control. Women who received the IPT had significantly better outcomes as compared to the waitlist control, in terms of symptom severity reductions, treatment response, and measures of psychosocial adjustment.xxxiii

### Cognitive Behavioral Therapy (CBT)

CBT targets problematic thinking patterns or behaviors that may be associated with depression. In CBT, patients learn skills to change negative patterns of thinking, learn to increase activities that improve their mood, and learn to solve life problems.xxxiv Depressed patients can learn how to change negative thought patterns to interpret their environment in a less negative way. With CBT, therapists and patients actively work together to help the patient recover from depression.xxxv According to Dimidjian and Goodman, little evidence exists that CBT is effective for individual psychotherapy in reducing perinatal anxiety and depression.xxxvixxxvii However, group-administered CBT has provided positive results in reducing postpartum depression:

* A study by Honey, et. al. (2002) found that an 8-week group treatment program that incorporated education, support, cognitive behavioral strategies, and relaxation was found to significant reduce symptoms of depression as compared to usual care among women with clinically significant levels of postpartum depression in a randomized controlled trial. The reduction in symptoms was maintained through 6 months.xxxviii
* An additional RCT by Meager and Milgrom (1996) found that 10 sessions of group CBT significantly improved postpartum depression symptoms as compared with a waitlist control.xxxix

*The reviews and meta-analyses did not describe the impact of CBT on antenatal depression or*

*throughout the perinatal period.*

For more information on IPT and CBT to treat perinatal depression, please refer to the following:

* Dimidjian, S., and Goodman, S. (2009). Nonpharmacologic intervention and prevention strategies for depression during pregnancy and the postpartum. *Clinical Obstetrics and Gynecology, 22*(3): 498-515.
* Sockol, L.E., Epperson, C.N., and Barber, J.P. (2011). A meta-analysis of treatments for perinatal depression. *Clinical Psychology Review, 31*: 839-849.

***Pharmacological Treatment Options***

Medication can also treat depression in pregnant women and in women who are breastfeeding. However, the benefits, risks, and alternatives of the medication must be discussed with the patient. A recent report from ACOG and the American Psychiatric Association indicates that prescribing medication for pregnant patients depends on the safety profile of the medications, the state of gestation, and the patient’s specific symptoms, history, and therapeutic preferences.[xl](#_bookmark27)The ACOG report includes suggestions for treating women who are contemplating pregnancy and already on antidepressants; women who are experiencing depression, are already pregnant, and who are not on antidepressants; and women who are experiencing depression, are already pregnant, and who are on antidepressants. If patients are pregnant and already taking antidepressants, providers may discuss with them whether they are willing to consider discontinuation of their medication, and what alternatives might be. If patients are not willing to stop using medication, their symptoms should be closely monitored throughout the pregnancy. For more information, see the article: Yonkers, K.A., et. al. (2009). The management of depression during pregnancy. A report from the American Psychiatric Association and the American College of Obstetricians and Gynecologists. *General Hospital Psychiatry, 31:* 403- 413.

ACOG also offers a Perinatal Depression Screening Toolkit that provides information about treating patients with depression. The toolkit offers an overview of various medications that may be prescribed for pregnant or postpartum women. The chart below is updated as of 2011.[xli,xlii,](#_bookmark28)xliii

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Antidepressant Medication** | **Advantages During Pregnancy** | **Disadvantages During Pregnancy** | **Estimated % of Maternal Dose to Breastfeeding****Baby\*\*** | **Reported Side Effects to Breastfeeding Babies\*\*\*** | **Teratogenicity (causing fetal malformations)** |
| Bupropion (Wellbutrin) | Fewer sexual side effectsLess excess weight gainHelps with smoking cessation | Limited data available Lowers seizure thresholdCan cause insomnia May increase risk of miscarriage | 2% | Seizures | Morphologic – limited evidence of cardiac malformations, increased risk for pulmonary hypertension Behavioral – limited evidenceof increased risk of ADHD |
| Citalopram | Few interactions with | Limited data | 0.7% - 9.0% | Uneasy sleep, | Morphologic – |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| (Celexa) | other medications | available |  | drowsiness, irritability, weight loss | risk of neural tube defectBehavioral – none found |
| Desipramine (Norpramin) | More studies in human pregnancy, including neurodevelopmental follow-up | Maternal side effects additive to pregnancy effects Orthostatic hypotension, | 1% | Agitation of newborn, potential triggering of seizure activity if there is a | None found |
|  |  | risking decreased placental perfusion Fetal and neonatal side effects: tachycardia, urinary retention |  | history of seizures |  |
| Desvenlafaxine | None specific, but may be optimal for some individualpatients | No systematic studies in humanpregnancy | Unknown | Unknown | Unknown |
| Duloxetine (Cymbalta) | Also treats diabetic peripheral neuropathic pain | No systemic studies in humanpregnancy | 0.1% | Unknown | Unknown |
| Escitalopram (Lexapro) | Few interactions with other medications | No systemic studies in humanpregnancy | 3.9% - 7.9% | Enterocolitis | Unknown |
| Fluoxetine (Prozac) | More studies inhuman pregnancy, including meta- analysis and neurodevelopmental follow up | More reports ofneonatal side effects than some other antidepressants | 1.2% - 12% | Excessive crying, irritability, vomiting, watery stools, difficulty sleeping, tremor, somnolence, hypotonia, decreasedweight gain, hyperglycemia | Morphologic:increased risk of cardiovascular malformations Behavioral – none found |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Mirtazapine (Remeron) | Fewer sexual side effectsHelps restore appetite in women who are not gaining weightLess likely to exacerbate nausea and vomiting | Limited data available Can cause excessive weight gain Tends to be sedating May increaserisk of pretermbirth | 0.6% - 2.8% | None | Morphologic – none found Behavioral - unknown |
| Nortriptyline (Pamelor) | More studies in human pregnancy, including neurodevelopmental follow-upBalanced antidepressant; may be effective whenselective agents are not | Maternal side effects additive to pregnancy effects Orthostatic hypotension, risking decreased placentalperfusion | 1.3% | None | None found |
| Paroexetine (Paxil) | Minimal association with cardiovascular malformations but may be optimal for some individual patients | More reports of neonatal side effects than most other antidepressants ACOGrecommends fetal echo for all exposedfetuses | 0.1% - 4.3% | Irritability, sleepiness, constipation, SIADH | Morphologic – possible increased risk of cardiovascular malformation Behavioral - unknown |
| Sertraline(Zoloft) | Relatively well-studied in human pregnancy Fewer reports ofneonatal side effects than other antidepressants | Minimalassociation with omphalocele and septal defects\* | 0.4% - 2.3% | Drug of choiceby OBs and pediatricians | Morphologic –unlikely increased risk of omphalocele and septic defects Behavioral – none found |
| Venlafaxine (Effexor) | None specific, but may be optimal for some individual patients | Limited data available | 5.2% - 7.6% | Decreased weight gain | Morphologic – none found Behavioral - unknown |

\*Absolute risk is small

\*\* These are weight-adjusted estimates that include the agent and its active metabolites.

\*\*\* These are based on case reports; this does not mean that it is confirmed to be due to the medicati

***Alternative Medicine Options***

Several alternative therapies to treat perinatal depression have been studied and may be options for patients experiencing perinatal depression:

* **Bright Light Therapy:** Through a randomized controlled trial, Epperson, et. al. (2004) found no difference between women receiving bright light therapy, similar to what one might receive for seasonal depression, and women in the control group over a 5-week prescribed period; however, women receiving bright light therapy over an additional

5-week period did reduce their depressive symptoms.[xliv](#_bookmark25) An additional review of bright light therapy in treating perinatal depression found that it appears effective for pregnant women, with a usual dose of up to 10,000 lx delivered for 30-60 minutes/day with a light box.[xlv](#_bookmark26)

* **Massage:** Field et. al. (2004) found significantly greater improvement in self-reported depression among patients assigned to massage therapy provided by their significant others[.xlvi](#_bookmark29)
* **Omega-3 fatty acids:** Placebo-controlled studies support the efficacy of using omega-3 fatty acids to reduce symptoms of depression in the general population, often as a supplement to pharmacotherapy or psychotherapy. An effective dose ranges from 0.5 –

3.4 grams in studies of perinatal depression.xlvii However, additional research is needed to determine efficacy in women experiencing perinatal depression. In two randomized placebo-controlled trials, no difference was found between omega-3 fatty acids and a placebo. However, an additional trial found significant benefit of omega-3 fatty acids compared with a placebo in reducing symptoms of antenatal depression.xlviii

*For more information on alternative medicine therapies to treat perinatal depression, please see: Freeman, M.P. (2009). Review: Complementary and alternative medicine for perinatal depression. Journal of Affective Disorders, 112: 1-10.*

Additional interventions have been found to reduce depression symptoms in the general adult population:

* **Exercise**: A study by Dunn, et. al., in the general adult population found that patients who completed the “public health dose” of exercise (17.5 kcal/kg/week with exercise 3 days/week or 5 days/week) experienced decreased symptoms of depression, showing that exercise is effective in the treatment of mild to moderate depression.[xlix](#_bookmark30)
* **Yoga**: A meta-analysis of randomized control trials of yoga interventions for depression by Cramer, et. al. found that yoga interventions had limited to moderate effectiveness in reducing the severity of depression symptoms in the general adult population. More specifically, the analysis found that meditation-based yoga interventions were effective in reducing depression symptoms, but that complex and exercise-based yoga interventions were not evidenced to reduce depression symptoms.[l](#_bookmark31) Another meta-analysis by Sheffield and Woods (2016) also concluded that yoga interventions are often effective in reducing anxiety and depression during pregnancy. [li](#_bookmark32)

# Referral for Treatment

Given the range of treatments described above, providers have multiple options for referring their patients to treatment if treatment cannot be provided in-house at the practice. A successful referral has two components: positive conversations with patients about referral options and positive relationships with mental health providers in the community.

### Initial Screening

Providers may use the following sample conversation tools, some from the [ACOG Perinatal](https://www.acog.org/programs/perinatal-mental-health/patient-screening)  [Depression Screening Toolkit](https://www.acog.org/programs/perinatal-mental-health/patient-screening) to assess their patients’ depression symptoms and need for treatment.

### Opening questions:

Patient 1

*“I’d like to hear about how you’re feeling since you’ve become pregnant. How have you been feeling lately”*[*lii*](#_bookmark33)

I’m doing great, except I’m tired all the time.

Patient 2

“*Since you are now in the third trimester of your pregnancy and getting closer to your delivery, I’d like to hear about how you are feeling lately. How have you been feeling”*[*liii*](#_bookmark34)

I’m ok, I’ve been feeling a little nervous about the baby coming and I just haven’t been feeling hungry.

Patient 3

*“Now that you’ve had your baby, I would like to know how you are feeling and how you have been coping lately”*[*liv*](#_bookmark35)

I’m feeling overwhelmed about everything I have to do to care for the baby.

### Screening:

#### Option 1: PRIME MD-2 Screen

*Those feelings all sound common during pregnancy. To learn a little more about how you’ve been feeling, I’d like you to ask you a few more questions.*

*During the past month, have you often been bothered by feeling down, depressed or hopeless?* I guess I’ve been feeling more down than normal lately, but I thought maybe the baby was just affecting my hormones.

*Ok. During the past month, have you often been bothered by little interest or pleasure in doing things?*

Not really. Because I’m so tired I don’t like to have people over like I used to, but that’s just because I haven’t been sleeping enough.

#### Option 2: Longer questionnaire like EPDS, PHQ9, etc.

*Those feelings all sound common during pregnancy. I’d like to learn more about how you’ve been feeling. Please complete this brief questionnaire.*

Providers can administer a screening tool such as the EPDS or PHQ9, verbally or on paper, and use the results to inform next steps about treatment. See Screening Tools for Anxiety and Depression During Pregnancy, above, for a description of different screening tools.

### Discussing Referrals with Patients

Once a patient has been screened and diagnosed with anxiety and/or depression, providers may discuss with them and recommend various options for treatment, including psychotherapy, pharmacotherapy, and alternative therapies, as described above.

The [ACOG Perinatal Mental Health Toolkit](https://www.acog.org/programs/perinatal-mental-health) describes statements that can be helpful in transitioning the conversation from diagnosis to referral, including:[lv](#_bookmark36)

*Overall treatment:* “From talking with you, I think you would benefit from treatment for anxiety or depression. The two most common forms of treatment are talk therapy/counseling and medication. Let’s talk about the benefits, risks, and alternatives of the various treatment options.”

*Counseling options:* “I would like you to speak with someone more about your feelings. This referral will help you take care of your health and your baby’s health.”

*Counseling options:* “Many women experience some anxiety or depression during or right after pregnancy. This referral does not mean that you are or will be a bad mother. However, not getting treatment could have adverse effects on your health and your child. I am concerned for your health and want you to speak with someone.”

*Medication:* “I want to discuss medications that could improve your mood. Have you taken medication in the past for anxiety or depression?”

“Was the medication effective?”

“From the conversation we just had, I’m going to prescribe for you. Let’s discuss this medication’s side effects, especially how it may impact your pregnancy and ability to breastfeed.”

Once a treatment option has been identified and agreed upon, providers may make a referral to a mental health specialist or community resource.

**Quick Tips:**

* **Build rapport and trust with one’s patients.**
* **Provide the patient with multiple treatment options.**
* **Involve the patient in the treatment and referral decision-making process.** Make sure to discuss the patient’s needs (location, time, price, etc.) and preferences (treatment type, language and cultural context, etc.) during the decision-making process. Then, let the patient decide which option is best for them!
* **Be proactive as a referring physician.** Keep a patient hand-out available with several trusted resources of different treatment types for the patient to choose from that can be accessed quickly and easily by the patient.

### Building Relationships with Mental Health Providers

Primary care providers and mental health providers can work together to ensure that positive relationships exist between them and that systems are created to ensure a smooth and more productive referral process. Multiple levels of collaboration are possible between primary care providers and mental health specialists, ranging from coordinated care to fully integrated, co- located care.

The most basic level of coordinated care between primary care and mental health specialists is a referral relationship. Primary care providers refer patients to mental health and other community resources, and a general exchange occurs between the two treatment settings. At the next level, collaboration at a distance entails primary care providers and mental health providers having separate systems and separate sites, but engaging in periodic communication about patients that they share. Rather than just referring the patient, primary care providers follow up to identify next steps and outcomes for their patients before resuming care if needed. That care often occurs by phone or letter, rather than in-person meetings.[lvi](#_bookmark44)

To further develop relationships with mental health specialists to whom primary care providers can refer patients, primary care providers may consider using some of the strategies recommended for establishing integrated care:

* Share tools: shared paper or electronic tools can improve diagnostics, communication, and patient tracking. These tools can include health history and screening tools, as well as a flow sheet for tracking depression scores, medication, and other mental health-related data;
* Develop a strong and trusting relationship: physicians and mental health specialists should meet regularly to discuss operational and clinical issues, encouraging open and honest communication;
* Consider including a mental health specialist on site at your practice[.lvii](#_bookmark46)

By continuing to build strong referral relationships with off-site or on-site mental health specialists, primary care providers can more easily ensure that their maternal patients are able to access the care they need when diagnosed with depression or anxiety.

***Agree***

After advising a patient of treatment options, it is very important that the patient and

provider reach an agreement regardless of the treatment plan decided upon. When making a referral, it is unfortunately very common for women not to follow-through on seeking mental health care after the initial referral to care has been made.lvii[i,](#_bookmark47) [lix](#_bookmark48)[,lx](#_bookmark49) There are a variety of factors that impact a woman’s decision whether to follow-through on a referral and, as stated above, these factors often lead to a lack of follow-through. Some of the barriers include: Significant others normalizing the patient’s emotional troubles[lxi](#_bookmark50), insecurity in seeking help for mental health issues from OB/GYN providers either for interpersonal (poor relationship or lack of trust in the provider) or time-related reasons[lxii,l](#_bookmark51)xii[i,lxiv](#_bookmark52), as well as stigma surrounding and wariness of taking medication, such as antidepressants, during pregnancy.[lxv](#_bookmark53)[,lxvi](#_bookmark37) However, there are a variety of actions on the part of providers that can occur during the Agree stage that are associated with greater referral uptake. One qualitative study found that women’s decision to discuss their mental health symptoms with a provider was closely tied to the answer to the question, “Can this person help me?”lxvii Whether the patient answers this question in the affirmative is tied to a variety offactors: the relationship with the physician, perceived competence of the physician, including the ability to make the right referral, and whether the patient felt there was effective communication surrounding the intervention focus and whether the patient felt her preferences were integrated in the discussion.

First, two components of the patient physician relationship found to be linked with referral follow-through were feeling heard and trust in the clinician.lxvi[i](#_bookmark38)[i](#_bookmark39)[,](#_bookmark38)[lxix](#_bookmark39)[,lxx](#_bookmark40)[,lxxi](#_bookmark41) Provider characteristics such as being sensitive and interested in the patient’s experience as well as cultural competency were closely tied with these components of the patient-provider relationship.lxxi[i,l](#_bookmark42)xxiii Creating an environment where the patient feels she can be honest with her provider is particularly important because women are far more likely to follow-through on a referral if they had confided in their provider that they may need care.lxxiv[,](#_bookmark43)[lxxv](#_bookmark45)

Second, the perceived competence of the clinician in making the referral was also tied to increased referral uptake. It was found to be important that the provider be proactive in providing g referral resources, recommend resources that can be accessed quickly and easily, and offer more than one treatment option.lxxvi Additionally, if possible, providers should refer to resources in the same clinic or healthcare setting to increase referral uptake. lxxvii, lxxviii

Finally, women were far more likely to follow-through with the referral if they felt that they were involved in the decision-making process. By engaging in a dialogue with patients, providing education regarding mental health issues and treatment choices, and respecting patient preferences, providers can increase the likelihood that patients will follow-through with a referral.lxxix[,](#_bookmark54)[lxxx,l](#_bookmark55)xxxi

***STAGE 4: ASSIST: Help patients identify barriers and problem solve***

Providers can help ASSIST their patients in identifying barriers to obtaining treatment and helping them identify ways to problem solve. The idea here is for you to help facilitate the process with the patient ultimately identifying ways to identify the best treatment for them and to overcome any potential barriers to meeting their treatment goals. Please see the videos below which display an interaction between a provider and patient while determining which treatment plan might be best for the patient.

Brief Motivational Interviewing Strategies to Enhance Patient-Provider Communication

There are key components of motivational interviewing that are effective strategies at enhancing patient-provider communication. These four key strategies include: Open-Ended Questions, Affirmations, Reflective Listening, and Summary Statements (OARS).

Open Ended Questions - Patients often shut down when they are simply told to change their behavior or in this case seek treatment. Open-ended questions encourage the patient to do most of the talking, foster rapport and build trust with the provider. Providers can respond to patients by listening carefully and responding with a reflective or summary statement.

Examples of open-ended questions:

“What makes you think it might be best to treat your depression?” “Tell me more about your experience with depression in the past?”

Affirmations - Providers can use affirmations to recognize patients’ strengths, successes and efforts to change. While it is important to acknowledge these efforts, it is also important that affirmations sound genuine.

“It’s clear to me that you are really trying to go to counseling regularly.” “You showed a lot of determination by doing that.”

Reflective Listening – Providers can use reflective listening to help build empathy with the patients by listening carefully to what the patient has to say and reflecting back what you have heard them say.

Examples of reflective listening “It sounds like …”

“So, what I hear you saying is…”

Summary Statements - Providers can use summary statements to link what a patient has already expressed and to move them on to another topic or expand the discussion.

Sometimes patients may become distressed when they are told that they have depression or anxiety. There are several steps providers can take to prepare for sharing potentially difficult news with patients:lxxxii

* Assess what the patient already believes or knows about depression and how much more information she wants.
* Be clear and direct about the patient’s depression diagnosis.
* Allow sufficient response time for the patient to process the diagnosis and experience their emotions.
* Discuss the implications of the diagnosis, offer more resources, identify next steps, summarize the discussion, and make a plan for following up with the patient.

There will be times when your patient is not receptive to seeking or adhering to treatment. In these cases, please consider using the 5Rs approach described below. The main point of the 5Rs is to highlight the benefits of treatment, and the negative consequences of not addressing their mood disorder. The key is to have the pros of treatment outweigh the cons. Once this is accomplished then help the patient identify why they would like to seek treatment. This will help the patient identify what motivates the patient to seek treatment. These steps may need to be addressed more than once to help move the patient to readiness. Once readiness is achieved, then proceed with the Stage 3 – Agree on Treatment Plan described above.

**When a -patient is not ready to take action the “5 R’s” can be used:**

1. ***Relevance*** *–assist patient to identify motivational factors and tailor importance for her personal situation*
2. ***Risks*** *– encourage patient to identify negative consequences of not treating mood disorder*
3. ***Rewards*** *– Ask how treating mood disorder might benefit her and her family*
4. ***Roadblocks*** *– Help patient identify barriers to treatment and to explore how to overcome these barriers*
5. ***Repetition*** *– Repeat at every visit.*

***STEP 5: ARRANGE – Mental health resources to help support for your patients***

There are many local and national resources that providers and patients may use to learn more about mental health providers in their areas.

When making referrals, it is important that the provider refer to the right resources for their patient taking into consideration factors such as:

* + Language preferences
	+ Waitlist times
	+ Financial factors (e.g. what insurance does the resource require (if any), what are the payment options?, does the resource offer a sliding-fee scale?)
	+ Location, (can the patient easily access the resource given their transportation situation?)

Certain organizations such as Postpartum Support International (see more information below) provide lists of local resources that have already been grouped by the above factors to help providers choose the most appropriate referrals.

**Quick Referral Checklist:**

When making a mental health referral, don’t forget the **LLAMA** in the room!

**L – Language:** Make sure the resource has the appropriate language options to meet the patients’ needs.

**L – Location:** Consider whether the resource is accessible given the patient’s address and transportation situation.

**A – Access:** How quickly can the patient access the resource? Are there long waitlists for the resource?

**M – Money:** Are the monetary requirements of the resource appropriate for the patient? What insurance does the resource require (if any)? What are the payment options?

Does the resource offer a sliding-fee scale?

**A – Agreement:** Does the patient agree that this resource may be a good option for them?

*In a hurry?* Postpartum Support International (PSI) offers resources and care coordination ersources. Access their [website or](http://www.postpartum.net/locations/colorado/) call 1-800-944-4773(4PPD).

For urgent situations, Colorado Crisis Services offers free, private, immediate support over the phone1-844-493-TALK (8255)

# Continuing Care

Once a patient has been referred to treatment, primary care providers should create a follow-up plan for that patient’s continued care. The “Perinatal Mental Health Toolkit” suggests the following steps:

**Quick Tip**

As a provider, you may have go- to practices with providers that you trust when you refer your patient to a specialist.

*Why not create the same relationship with several mental health providers?* Establish relationships with several vetted mental health providers who you trust and feel comfortable referring patients to. Better yet, establish in-office procedures for a warm hand-off when referring patients to these providers.

* + “Everyone receiving well-woman, pre-pregnancy, prenatal, and postpartum care be screened for depression and anxiety

using standardized, validated instruments”

* + “Screening for perinatal depression and anxiety occur at the initial prenatal visit, later in pregnancy, and at postpartum visits”
	+ “Mental health screening be implemented with systems in place to ensure timely access to assessment and diagnosis, effective treatment, and appropriate monitoring and follow- up, based on severity”
	+ “Screening for bipolar disorder be done before initiating pharmacotherapy for anxiety or depression, if not previously done”
	+ “When someone answers a self-harm or suicide question affirmatively, clinicians immediately assess for likelihood, acuity, and severity of risk of suicide attempt and then arrange for risk-tailored management”
	+ “Clinicians provide immediate medical attention for postpartum psychosis” lxxxiii

**Resources for Providers and Patients**

There are many local and national resources that providers and patients may use to learn more about mental health providers in their areas. Providers that explicitly state that they offer resources in multiple languages (mainly Spanish) or targeting specific communities are marked with an asterisk (\*). Resources that offer local programs or support in Colorado and Virginia are specifically identified.

*National resources*

* [**National Alliance on Mental Illness (NAMI)**](https://www.nami.org/)

A nonprofit organization that provides support, education, awareness, advocacy, and research on mental health issues at a national level. There are local chapters and affiliates in each state.

* [**National Suicide Prevention Lifeline**](http://www.suicidepreventionlifeline.org/)

A 24/7 hotline that connects callers with a trained counselor at a crisis center in the caller’s area. The site also has a Lifeline Crisis Chat, which allows visitors to receive online support and crisis intervention. The phone number is 1-800-273-TALK (8255).

* [**Postpartum Progress**](http://www.postpartumprogress.com/)

A website offering information and an online community for pregnant women and new moms experiencing depression during pregnancy or after child birth. The site and blog postings are reviewed by experts to ensure that they are correct. Resources are also available for medical providers.

*Colorado resources*

* [Postpartum Support International](https://www.postpartum.net/)

A non-profit organization whose mission is to promote awareness, prevention and treatment of mental health issues related to childbearing in every country worldwide. They offer a state-by-state listing of resources related to postpartum depression as well as contact information for coordinators in each state who can provide support. The website includes resources for women, dads and partners, and providers. They also have resources in Spanish and links for other languages.

* + [**Children’s Hospital Colorado’s Healthy Expectations Perinatal Mental Health Program**](https://www.childrenscolorado.org/doctors-and-departments/departments/psych/programs/mental-health-moms/)

The program offers support groups, individual and couples counseling, group therapy, and support for mothers and infants in the postpartum period. There is also a weekly support group for pregnant women.

* + [**Colorado Behavioral Healthcare Council (CBHC)**](https://www.cbhc.org/)

The statewide membership organization for Colorado’s community behavioral health providers, who provide or contract for direct service in delivery sites across the state. A complete list of members is available on their website. Many members offer programming and treatment specifically for pregnant and postpartum women and their families. The Denver Metro area has several community mental health centers:

* + 1. [**Arapahoe/Douglas Mental Health Network**](https://www.allhealthnetwork.org/)
		2. [**Aurora Mental Health Center\***](http://www.aumhc.org/)
		3. [**Community Reach Center\***](http://www.communityreachcenter.org/)
		4. [**Jefferson Center for Mental Health\***](http://www.jcmh.org/)
		5. [**Mental Health Center of Denver\***](http://www.mhcd.org/)
	+ Other Metro Denver-area clinics that provide mental health services:
		1. [**Asian Pacific Development Center**](http://www.apdc.org/)\*
		2. Clinica Tepeyac\*
		3. [**Inner City Health Cente**](http://innercityhealth.org/)r\*
		4. [**Servicios de la Raza**](http://www.serviciosdelaraza.org/)\*

*Virginia resources*

* + - * Postpartum Support Virginia <http://www.postpartumva.org/>

The Virginia chapter of this international group is very active and coordinates local support groups while maintaining a statewide list of resources for women and families who experience mental health difficulties during pregnancy and the postpartum.

* + - * Services for Military Veterans and their Families <https://www.womenshealth.va.gov/OutreachMaterials/ReproductiveHealth/PostpartumDepression.asp>

The Veterans Administration offers a range of services for veterans and family members of veterans who are experiencing mental health difficulties during pregnancy and the postpartum.

* + - * Services for Active Duty Military Personnel and their Families [https://www.militaryonesource.mil/-/potential-signs-of-postpartum-](https://www.militaryonesource.mil/-/potential-signs-of-postpartum-depression?redirect=https%3A%2F%2Fwww.militaryonesource.mil%2Fmental-health-resources%3Fp_p_id%3D3%26p_p_lifecycle%3D0%26p_p_state%3Dmaximized%26p_p_mode%3Dview%26_3_groupId%3D20182%26_3_keywords%3Dpostpartum%26_3_struts_action%3D%252Fsearch%252Fsearch%26_3_redirect%3D%252Fmental-health-resources&inheritRedirect=true) [depression?redirect=https%3A%2F%2Fwww.militaryonesource.mil%2Fmental-health-](https://www.militaryonesource.mil/-/potential-signs-of-postpartum-depression?redirect=https%3A%2F%2Fwww.militaryonesource.mil%2Fmental-health-resources%3Fp_p_id%3D3%26p_p_lifecycle%3D0%26p_p_state%3Dmaximized%26p_p_mode%3Dview%26_3_groupId%3D20182%26_3_keywords%3Dpostpartum%26_3_struts_action%3D%252Fsearch%252Fsearch%26_3_redirect%3D%252Fmental-health-resources&inheritRedirect=true)

[resources%3Fp\_p\_id%3D3%26p\_p\_lifecycle%3D0%26p\_p\_state%3Dmaximized%26p\_p\_mode%3Dview%](https://www.militaryonesource.mil/-/potential-signs-of-postpartum-depression?redirect=https%3A%2F%2Fwww.militaryonesource.mil%2Fmental-health-resources%3Fp_p_id%3D3%26p_p_lifecycle%3D0%26p_p_state%3Dmaximized%26p_p_mode%3Dview%26_3_groupId%3D20182%26_3_keywords%3Dpostpartum%26_3_struts_action%3D%252Fsearch%252Fsearch%26_3_redirect%3D%252Fmental-health-resources&inheritRedirect=true) [26\_3\_groupId%3D20182%26\_3\_keywords%3Dpostpartum%26\_3\_struts\_action%3D%252Fsearch%252Fse](https://www.militaryonesource.mil/-/potential-signs-of-postpartum-depression?redirect=https%3A%2F%2Fwww.militaryonesource.mil%2Fmental-health-resources%3Fp_p_id%3D3%26p_p_lifecycle%3D0%26p_p_state%3Dmaximized%26p_p_mode%3Dview%26_3_groupId%3D20182%26_3_keywords%3Dpostpartum%26_3_struts_action%3D%252Fsearch%252Fsearch%26_3_redirect%3D%252Fmental-health-resources&inheritRedirect=true) [arch%26\_3\_redirect%3D%252Fmental-health-resources&inheritRedirect=true](https://www.militaryonesource.mil/-/potential-signs-of-postpartum-depression?redirect=https%3A%2F%2Fwww.militaryonesource.mil%2Fmental-health-resources%3Fp_p_id%3D3%26p_p_lifecycle%3D0%26p_p_state%3Dmaximized%26p_p_mode%3Dview%26_3_groupId%3D20182%26_3_keywords%3Dpostpartum%26_3_struts_action%3D%252Fsearch%252Fsearch%26_3_redirect%3D%252Fmental-health-resources&inheritRedirect=true)

All branches of the US Armed Forces offer a range of treatment and support services for expecting and new parents.

* + - * Virginia Community Services Boards <http://www.dbhds.virginia.gov/community-services-boards-csbs>

Community Services Boards in Virginia exist in all communities and provide a mix of direct services and referral resources to members of the local community.

**Best Practice Guidelines – Summary**

## ASSESS

* + - * **Screening**: Have a clinic protocol to screen every patient at intervals throughout the pregnancy and postpartum periods.

## ADVISE

* + - * Advise patients of **multiple treatment options** and work with the patient to develop a treatment plan that works.

## AGREE

### Build rapport and trust with one’s patients.

* + - * **Involve the patient in the treatment and referral decision-making process.** Make sure to discuss the patient’s needs (location, time, price, etc.) and preferences (treatment type, language and cultural context, etc.) during the decision-making process. Then, let the patient decide which option is best for them!

## ASSIST

* + - * Help patients to identify barriers to obtaining treatment and help them identify ways to problem solve to with the ultimate goal of identifying the best treatment for them and to overcoming any potential barriers to meeting their treatment goals

## ARRANGE

### Use the Quick Referral Checklist:

When making a mental health referral, don’t forget the **LLAMA** in the room!

**L – Language:** Make sure the resource has the appropriate language options to meet the patients’ needs.

**L – Location:** Consider whether the resource is accessible given the patient’s address and transportation situation.

**A – Access:** How quickly can the patient access the resource? Are there long waitlists for the resource?

**M – Money:** Are the monetary requirements of the resource appropriate for the patient? What insurance does the resource require (if any)? What are the payment options? Does the resource offer a sliding-fee scale?

**A – Agreement:** Does the patient agree that this resource may be a good option for them?

* + - * **Form referral relationships with several mental health providers.** Establish relationships with several vetted mental health providers who you trust and feel comfortable referring patients to.
			* **Be proactive as a referring physician.** Keep a patient hand-out available with several trusted resources of different treatment types for the patient to choose from that can be accessed quickly and easily by the patient.
			* **Establish a warm hand-off procedure for mental health referrals.** Create clinic procedures for patients to make an appointment with mental health resource of choice before leaving the office and conducting appropriate in-clinic monitoring of referral follow-through.
1. Bennett HA, Einarson A, Taddio A, Koren G, Einarson TR. Prevalence of depression during pregnancy: systematic review Obstet and Gynecol 2004;103(4):698-709.
2. Austin MP; Hadzi-Pavlovic D; Leader L, et al. Maternal trait anxiety, depression and life event stress in pregnancy: relationships with infant temperament. 2005; 81, pp. 183-90.
3. Andersson L, Sundstrom-Poromaa I, Wulff M, Astrom M, Bixo M. Neonatal outcome following maternal antenatal depression and anxiety: A population-based study. Am J Epidemiol 2004;159(9):872-81.
4. Dole N, Savitz DA, Hertz-Picciotto I, Siega-Riz AM, McMahon MJ, Buekens P. Maternal stress and preterm birth. Am J Epidemiol 2003;157(1):14-24.
5. Andersson L, Sundstrom-Poromaa I, Wulff M, Astrom M, Bixo M. Neonatal outcome following maternal antenatal depression and anxiety: A population-based study. Am J Epidemiol 2004;159(9):872- 81.
6. O'Connor TG, Heron J, Golding J, Beveridge M, Glover V. Maternal antenatal anxiety and children's behavioural/emotional problems. Report from the Avon Longitudinal Study of Parents and Children. Br J Psychiatry 2002;180:502-8.
7. Josefsson A, Berg G, Nordin C, Sydjo G. Prevalence of depressive symptoms in late pregnancy and postpartum. Acta Obstet Gynecol Scand 2001;80:251-55.
8. Brennan PA, Hammen C, Andersen MJ, Bor W. Chronicity, severity, and timing of maternal depressive symptoms: relationship with child outcomes at age 5. Dev Psychol 2000;36(6):759-66.
9. Department of Health and Human Services, Office on Women’s Health. (2009). Depression during and after pregnancy. Available at: [https://www.womenshealth.gov/publications/our-publications/fact-sheet/depression-](https://www.womenshealth.gov/publications/our-publications/fact-sheet/depression-pregnancy.pdf) [pregnancy.pdf.](https://www.womenshealth.gov/publications/our-publications/fact-sheet/depression-pregnancy.pdf) Accessed April 22, 2014.

x Yonkers, K.A., Wisner, K.L., Stewart, D.E., Oberlander, T.F., Dell, D.L., Stotland, N., Ramin, S., Chaudron, L., and Lockwood, C. (2009). The management of depression during pregnancy. A report from the American Psychiatric Association and the American College of Obstetricians and Gynecologists. *General Hospital Psychiatry, 31:* 403-413.

xi Department of Health and Human Services, Office on Women’s Health. (2009). Depression during and after pregnancy. Available at: [https://www.womenshealth.gov/publications/our-publications/fact-sheet/depression-](https://www.womenshealth.gov/publications/our-publications/fact-sheet/depression-pregnancy.pdf) [pregnancy.pdf.](https://www.womenshealth.gov/publications/our-publications/fact-sheet/depression-pregnancy.pdf) Accessed April 22, 2014.

xii Dunkel Schetter, C. (2011). Psychological science on pregnancy: Stress processes, biopsychosocial models, and emerging research issues. *Annual Review of Psychology, 62:* 531-558.

xiii Field, T., Diego, M., Hernandez-Reif, M., Figueiredo, B., Deeds, O., Ascencio, A., Schanberg, S., and Kuhn, C. (2010). Comorbid depression and anxiety effects on pregnancy and neonatal outcome. *Infant Behavior and Development, 33*(1), 23-29.

xiv Ding, X., Wu, Y, Xu, S., Zhu, R., Jia, X., Zhang, S., Huang, K…and Tao, F. (2014). Maternal anxiety during pregnancy and adverse birth outcomes: A systematic review and meta analysis of prospective cohort studies. *Journal of Affective Disorders, 159:* 103-110.

xv Dunkel Schetter, C., and Tanner, L. (2012). Anxiety, depression, and stress in pregnancy: implications for mothers, children, research, and practice. *Current Opinions in Psychiatry, 25*: 141-148.

xvi University of Michigan Medical School. A woman’s guide to understanding depression: the symptoms of depression during pregnancy. Available at: [http://www.med.umich.edu/womensguide/pages/06.html.](http://www.med.umich.edu/womensguide/pages/06.html) Accessed April 22, 2014.

xvii The MacArthur Initiative on Depression and Primary Care and 3CM. (2009). Depression Management Tool Kit. Available at: [http://prevention.mt.gov/suicideprevention/13macarthurtoolkit.pdf.](http://prevention.mt.gov/suicideprevention/13macarthurtoolkit.pdf)

xviii American College of Obstetricians and Gynecologists. (no date). Frequently Asked Questions – Depression. Available at: [http://www.acog.org/~/media/For%20Patients/faq106.pdf?dmc=1&ts=20140422T2338195148.](http://www.acog.org/~/media/For%20Patients/faq106.pdf?dmc=1&amp%3Bts=20140422T2338195148) Accessed April 22, 2014.

xix Postpartum Support International. (2014). Anxiety during pregnancy & postpartum. Available at: [http://www.postpartum.net/Get-the-Facts/Anxiety-During-Pregnancy-Postpartum.aspx.](http://www.postpartum.net/Get-the-Facts/Anxiety-During-Pregnancy-Postpartum.aspx) Accessed June 16, 2014.

xx American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. Arlington, VA, American Psychiatric Association, 2013. Web. [access date: 28 May 2014]. dsm.psychiatryonline.org

xxi American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. Arlington, VA, American Psychiatric Association, 2013. Web. [access date: 28 May 2014]. dsm.psychiatryonline.org

xxii American College of Nurse-Midwives. (2013). Position statement – depression in women. Available at: [http://www.midwife.org/ACNM/files/ACNMLibraryData/UPLOADFILENAME/000000000061/Depression%20in](http://www.midwife.org/ACNM/files/ACNMLibraryData/UPLOADFILENAME/000000000061/Depression%20in%20Women%20May%202013.pdf)

[%20Women%20May%202013.pdf.](http://www.midwife.org/ACNM/files/ACNMLibraryData/UPLOADFILENAME/000000000061/Depression%20in%20Women%20May%202013.pdf) Accessed April 22, 2014.

xxiii American Academy of Family Physicians. (2010). Clinical recommendation: depression. Available at: [http://www.aafp.org/patient-care/clinical-recommendations/all/depression.html.](http://www.aafp.org/patient-care/clinical-recommendations/all/depression.html) Accessed April 22, 2014

xxiv The American College of Obstetricians and Gynecologists, Committee on Obstetric Practice. (2010). Committee opinion number 453: Screening for depression during and after pregnancy. Available at: [http://www.acog.org/~/media/Committee%20Opinions/Committee%20on%20Obstetric%20Practice/co453.pdf?dmc](http://www.acog.org/~/media/Committee%20Opinions/Committee%20on%20Obstetric%20Practice/co453.pdf?dmc=1&amp%3Bts=20140405T1637521474)

[=1&ts=20140405T1637521474.](http://www.acog.org/~/media/Committee%20Opinions/Committee%20on%20Obstetric%20Practice/co453.pdf?dmc=1&amp%3Bts=20140405T1637521474) Accessed April 7, 2014.

xxv Corby-Edwards, A., on behalf of the American Psychological Association. (2014). Re: U.S. Preventive Services Task Force DRAFT Research Plan – Primary Care Screening for Depression in Adults. Available at: [http://www.apa.org/about/gr/pi/news/2014/perinatal-depression-screening.pdf.](http://www.apa.org/about/gr/pi/news/2014/perinatal-depression-screening.pdf) Accessed June 16, 2014.

xxvi Kroenke, K., Spitzer, R.L., Williams, J.B.W., et. al. (2007). Anxiety disorders in primary care: prevalence, impairment, comorbidity, and detection. *Annals of Internal Medicine, 146:* 317-325.

xxvii Eack, S.M., Singer, J.B., and Greeno, C.G. (2008). Screening for anxiety and depression in community mental health: The Beck Anxiety and Depression Inventories. *Community Mental Health Journal,* 44: 465-474.

xxviii American College of Obstetricians and Gynecologists. (2008). *Perinatal Depression Screening: Tools for Obstetrician-Gynecologists.* Available at: [http://mail.ny.acog.org/website/DepressionToolKit.pdf.](http://mail.ny.acog.org/website/DepressionToolKit.pdf)

xxix Dimidjian, S., and Goodman, S. (2009). Nonpharmacologic intervention and prevention strategies for depression during pregnancy and the postpartum. *Clinical Obstetrics and Gynecology, 22*(3): 498-515.

xxx Weissman, M.M., Klerman, G.L., Wolman B.B. (ed.) and Stricker, G. (ed.). (1990). Interpersonal psychotherapy for depression. *Depressive disorders: Facts, theories, and treatment methods.* Oxford, England: John Wiley & Sons. xxxi Spinelli, M.G., Enidcott, J. (2003). Controlled clinical trial of interpersonal psychotherapy versus parenting education program for depressed pregnant women. *American Journal of Psychiatry, 160*: 555-562.

xxxii Grote, N.K., Swartz, H.A., Geibel, S.L., Zuckoff, A., Houck, P.R., and Frank, E. (2009). A randomized controlled trial of culturally relevant, brief interpersonal psychotherapy for perinatal depression. *Psychiatric services, 60*(3), 313-321.

xxxiii O’Hara, M.W., Stuart, S., Gorman, L.L. et. al. (2000). Efficacy of interpersonal psychotherapy for postpartum depression. *Archives of General Psychiatry, 57:* 1039-1045.

xxxiv Dimidjian, S., and Goodman, S. (2009). Nonpharmacologic intervention and prevention strategies for depression during pregnancy and the postpartum. *Clinical Obstetrics and Gynecology, 22*(3): 498-515. xxxv National Alliance on Mental Illness. (2012). Cognitive Behavioral Therapy Fact Sheet. Available at: [http://www.nami.org/factsheets/CBT\_factsheet.pdf.](http://www.nami.org/factsheets/CBT_factsheet.pdf) Accessed May 4, 2014.

xxxvi Green, S. M., Haber, E., Frey, B. N., & McCabe, R. E. (2015). Cognitive-behavioral group treatment for perinatal anxiety: a pilot study. *Archives of women's mental health*, *18*(4), 631-638.

xxxvii Dimidjian, S., and Goodman, S. (2009). Nonpharmacologic intervention and prevention strategies for depression during pregnancy and the postpartum. *Clinical Obstetrics and Gynecology, 22*(3): 498-515.

xxxviii Honey, K.L., Bennett, P., and Morgan, M. (2002). A brief psycho-educational group intervention for postnatal depression. *British Journal of Clinical Psychology, 41:* 405-409.

xxxix Meager, I. and Milgrom, J. (1996). Group treatment for postpartum depression: a pilot study. *Australia and New Zealand Journal of Psychiatry, 30:* 852-860.

xl Yonkers, K.A., Wisner, K.L., Stewart, D.E., Oberlander, T.F., Dell, D.L., Stotland, N., Ramin, S., Chaudron, L., and Lockwood, C. (2009). The management of depression during pregnancy. A report from the American Psychiatric Association and the American College of Obstetricians and Gynecologists. *General Hospital Psychiatry, 31:* 403-413.

xli American College of Obstetricians and Gynecologists. (2008). *Perinatal Depression Screening: Tools for Obstetrician-Gynecologists.* Available at: [http://mail.ny.acog.org/website/DepressionToolKit.pdf.](http://mail.ny.acog.org/website/DepressionToolKit.pdf)

xlii Information for Providers on Antidepressants during pregnancy and breast feeding – September 2011. <http://www2.illinois.gov/hfs/SiteCollectionDocuments/mch_medchart.pdf>

xliii Physicians Desk Reference

xliv Epperson, C.N., Terman, M., Terman, J.S., Hanusa, B.H., Gren, D.A., Peindl, K.S. and Wisner, K.L. (2004). Randomized clinical trial of bright light therapy for antepartum depression: preliminary findings. *Journal of Clinical Psychiatry, 65*(3), 421-425.

xlv Freeman, M.P. (2009). Review: Complementary and alternative medicine for perinatal depression. *Journal of Affective Disorders, 112:* 1-10.

xlvi Field, T., Diego, M.A., Hernandez-Reif, M., Schanberg, S., and Kuhn, C. Massage therapy effects on depressed pregnant women. *J Psychosom Obstet Gynecol, 25,* 115 – 122.

xlvii Freeman, M.P. (2009). Review: Complementary and alternative medicine for perinatal depression. *Journal of Affective Disorders, 112:* 1-10.

xlviii Freeman, M.P. (2009). Review: Complementary and alternative medicine for perinatal depression. *Journal of Affective Disorders, 112:* 1-10.

xlixDunn, A.L., Madhukar, H.T., Kampert, J.B., Clark, C.G., and Chambliss, H.O. (2005). Exercise treatment for depression: Efficacy and dose response. *American Journal of Preventive Medicine, 28*(1).

l Cramer, H., Lauche, R., Langhorst, J., and Dobos, G. (2013). Yoga for depression: a systematic review and meta- analysis. *Depression and Anxiety: 30,* 1068-1083.

li Sheffield, K. M., & Woods-Giscombé, C. L. (2016). Efficacy, Feasibility, and Acceptability of Perinatal Yoga on Women’s Mental Health and Well-Being A Systematic Literature Review.*Journal of Holistic Nursing*, *34*(1), 64-79.

lii American College of Obstetricians and Gynecologists. (2008). *Perinatal Depression Screening: Tools for Obstetrician-Gynecologists.* Available at: [http://mail.ny.acog.org/website/DepressionToolKit.pdf.](http://mail.ny.acog.org/website/DepressionToolKit.pdf)

liii American College of Obstetricians and Gynecologists. (2008). *Perinatal Depression Screening: Tools for Obstetrician-Gynecologists.* Available at: [http://mail.ny.acog.org/website/DepressionToolKit.pdf.](http://mail.ny.acog.org/website/DepressionToolKit.pdf)

liv American College of Obstetricians and Gynecologists. (2008). *Perinatal Depression Screening: Tools for Obstetrician-Gynecologists.* Available at: [http://mail.ny.acog.org/website/DepressionToolKit.pdf.](http://mail.ny.acog.org/website/DepressionToolKit.pdf)

lv American College of Obstetricians and Gynecologists. (2008). *Perinatal Depression Screening: Tools for Obstetrician-Gynecologists.* Available at: [http://mail.ny.acog.org/website/DepressionToolKit.pdf.](http://mail.ny.acog.org/website/DepressionToolKit.pdf)

lvi Collins, C., Hewson, D.L., Munger, R., and Wade, T. (Millibank Fund). (2010). Evolving Models of Behavioral Health Integration in Primary Care. Available at: [http://www.milbank.org/uploads/documents/10430EvolvingCare/EvolvingCare.pdf.](http://www.milbank.org/uploads/documents/10430EvolvingCare/EvolvingCare.pdf) Accessed June 14, 2014.

lvii Reitz, R., Fifield, P., Whistler, P. (2011). Integrating a behavioral health specialist into your practice. *Family Practice Management, 18*(1): 18-21*.* Available at: [http://www.aafp.org/fpm/2011/0100/p18.html.](http://www.aafp.org/fpm/2011/0100/p18.html) Accessed June 15, 2014.

lviii Ishikawa, R. Z., Cardemil, E. V., Alegría, M., Schuman, C. C., Joseph, R. C., & Bauer, A. M. (2014). *Uptake of*

*depression treatment recommendations among Latino primary care patients* (Vol. 11, No. 4, p. 421). Educational Publishing Foundation.

lix Kim, J. J., La Porte, L. M., Corcoran, M., Magasi, S., Batza, J., & Silver, R. K. (2010). Barriers to mental health

treatment among obstetric patients at risk for depression. *American journal of obstetrics and gynecology*, *202*(3), 312-e1.

lx Henshaw, E., Sabourin, B., & Warning, M. (2013). Treatment-seeking behaviors and attitudes survey among

women at risk for perinatal depression or anxiety.. *Journal of Obstetric, Gynecologic, & Neonatal Nursing*, *42*(2), 168-177.

lxi Kingston, D., Austin, M. P., Heaman, M., McDonald, S., Lasiuk, G., Sword, W., ... & Kingston, J. (2015). Barriers and facilitators of mental health screening in pregnancy. *Journal of affective disorders*, *186*, 350-357. lxii Bennett, I. M., Palmer, S., Marcus, S., Nicholson, J. M., Hantsoo, L., Bellamy, S., ... & Coyne, J. C. (2009). “One end has nothing to do with the other:” Patient attitudes regarding help seeking intention for depression in gynecologic and obstetric settings. *Archives of women's mental health*,*12*(5), 301-308.

lxiii Kingston, D., Austin, M. P., Heaman, M., McDonald, S., Lasiuk, G., Sword, W., ... & Kingston, J. (2015). Barriers and facilitators of mental health screening in pregnancy. *Journal of affective disorders*, *186*, 350-357. lxiv Smith, M. V., Shao, L., Howell, H., Wang, H., Poschman, K., & Yonkers, K. A. (2009). Success of mental health referral among pregnant and postpartum women with psychiatric distress. *General hospital psychiatry*, *31*(2), 155-162.

lxv Smith, M. V., Shao, L., Howell, H., Wang, H., Poschman, K., & Yonkers, K. A. (2009). Success of mental health

referral among pregnant and postpartum women with psychiatric distress. *General hospital psychiatry*, *31*(2), 155- 162.

lxvi Flynn HA, Henshaw E, O’Mahen H, Forman J. (2010). Patient perspectives on improving the depression referral processes in obstetrics settings: a qualitative study. General Hospital Psychiatry 32: 9-16.

11.

lxvii Henshaw, E. J., Flynn, H. A., Himle, J. A., O'Mahen, H. A., Forman, J., & Fedock, G. (2011). Patient preferences for clinician interactional style in treatment of perinatal depression. *Qualitative health research*, 1049732311403499.

lxviii Henshaw, E. J., Flynn, H. A., Himle, J. A., O'Mahen, H. A., Forman, J., & Fedock, G. (2011). Patient

preferences for clinician interactional style in treatment of perinatal depression. *Qualitative health research*, 1049732311403499.

lxix Kingston, D., Austin, M. P., Heaman, M., McDonald, S., Lasiuk, G., Sword, W., ... & Kingston, J. (2015). Barriers and facilitators of mental health screening in pregnancy. *Journal of affective disorders*, *186*, 350-357.

lxx Ishikawa, R. Z., Cardemil, E. V., Alegría, M., Schuman, C. C., Joseph, R. C., & Bauer, A. M. (2014). *Uptake of*

*depression treatment recommendations among Latino primary care patients* (Vol. 11, No. 4, p. 421). Educational Publishing Foundation.

lxxi Smith, M. V., Shao, L., Howell, H., Wang, H., Poschman, K., & Yonkers, K. A. (2009). Success of mental

health referral among pregnant and postpartum women with psychiatric distress. *General hospital psychiatry*, *31*(2), 155-162.

lxxii Kingston, D., Austin, M. P., Heaman, M., McDonald, S., Lasiuk, G., Sword, W., ... & Kingston, J. (2015). Barriers and facilitators of mental health screening in pregnancy. *Journal of affective disorders*, *186*, 350-357.

lxxiii Ishikawa, R. Z., Cardemil, E. V., Alegría, M., Schuman, C. C., Joseph, R. C., & Bauer, A. M. (2014). *Uptake of*

*depression treatment recommendations among Latino primary care patients* (Vol. 11, No. 4, p. 421). Educational Publishing Foundation.

lxxiv Smith, M. V., Shao, L., Howell, H., Wang, H., Poschman, K., & Yonkers, K. A. (2009). Success of mental

health referral among pregnant and postpartum women with psychiatric distress. *General hospital psychiatry*, *31*(2), 155-162.

lxxv Kim, J. J., La Porte, L. M., Corcoran, M., Magasi, S., Batza, J., & Silver, R. K. (2010). Barriers to mental health

treatment among obstetric patients at risk for depression. *American journal of obstetrics and gynecology*, *202*(3), 312-e1.

lxxvi Flynn HA, Henshaw E, O’Mahen H, Forman J. (2010). Patient perspectives on improving the depression referral processes in obstetrics settings: a qualitative study. General Hospital Psychiatry 32: 9-16.

11.

lxxvii Flynn HA, Henshaw E, O’Mahen H, Forman J. (2010). Patient perspectives on improving the depression referral processes in obstetrics settings: a qualitative study. General Hospital Psychiatry 32: 9-16.

11.

lxxviii Smith, M. V., Shao, L., Howell, H., Wang, H., Poschman, K., & Yonkers, K. A. (2009). Success of mental health referral among pregnant and postpartum women with psychiatric distress. *General hospital psychiatry*, *31*(2), 155-162.

lxxix Henshaw, E. J., Flynn, H. A., Himle, J. A., O'Mahen, H. A., Forman, J., & Fedock, G. (2011). Patient

preferences for clinician interactional style in treatment of perinatal depression. *Qualitative health research*, 1049732311403499.

lxxx Rowan, P. J., Greisinger, A., Upadhyaya, M., & Smith, F. (2015). Why Don’t Depressed Pregnant Women Follow Through With Mental Health Referral?. *Womens Health, Issues and Care*,*2013*.

lxxxi Ishikawa, R. Z., Cardemil, E. V., Alegría, M., Schuman, C. C., Joseph, R. C., & Bauer, A. M. (2014). *Uptake of*

*depression treatment recommendations among Latino primary care patients* (Vol. 11, No. 4, p. 421). Educational Publishing Foundation.

lxxxii Hull, S.K., and Broquet, K. (2007). How to manage difficult patient encounters. *Family Medicine Practice,*

June: 30-34. Available at: [http://www.aafp.org/fpm/2007/0600/p30.pdf.](http://www.aafp.org/fpm/2007/0600/p30.pdf) Accessed June 14, 2014.

lxxxiii American College of Obstetricians and Gynecologists. (2008). *Perinatal Depression Screening: Tools for Obstetrician-Gynecologists.* Available at: [http://mail.ny.acog.org/website/DepressionToolKit.pdf.](http://mail.ny.acog.org/website/DepressionToolKit.pdf)

lxxxiv HealthTeamWorks and Colorado Department of Public Health and Environment. (no date). Pregnancy-related

depressive symptoms resources: For professionals. Available at: [https://www.colorado.gov/cdphe/pregnancy-](https://www.colorado.gov/cdphe/pregnancy-related-depression-resources-providers) [related-depression-resources-providers. Accessed August](http://healthteamworks-media.precis5.com/ded959434b964227b085fcb4c1a4e108) 16, 2014.