NC MATTERS

Perinatal Depression Toolkit

Perinatal depression is defined as the occurrence of major or minor depressive episodes during pregnancy or within the first 12 months postpartum.

In the United States, about 1 in 8 women (12.5%) report symptoms of postpartum depression.[1]

RISK FACTORS[2]

- Personal or family history of mental illness
- History of pregnancy complications or loss
- Exposure to childhood abuse, domestic violence, or sexual assault
- Difficulties with breastfeeding
- Economic stressors
- Limited social support
- Immigration status (e.g., recent arrival, refugee, insecure/undocumented status)
- Sensitivity to hormonal changes

HEALTH DISPARITIES[3, 4]

- Higher prevalence is often reported among women of color, low-income populations, and those with limited access to health care.
- Black and Hispanic women in the U.S. experience higher rates of postpartum depression symptoms but are less likely to receive treatment.

CLINICAL PRESENTATION[5, 6]

Psychological Symptoms

- Persistent sad or depressed mood
- Loss of interest or pleasure in activities
- Feeling worthless or guilty
- Difficulty thinking, concentrating, or making decisions
- Difficulty bonding with infant
- Anxiety and irritability
- Thoughts of death or suicide

Common Worry Themes

- Health and safety of the fetus and/or the infant
- Parenting abilities
- Unwanted, intrusive thoughts of infant-related harm
- Personal health and safety

Physical Symptoms

- Changes in appetite
- Trouble sleeping or sleeping too much
- Loss of energy or increased fatigue
- Increased psychomotor agitation (e.g., fidgeting, pacing) or retardation (e.g., slowed movements or speech that can be observed by others)
- Gastrointestinal symptoms, headaches, or other reported physical discomfort

"I am really struggling to feel connected to the baby. Shouldn't I be enjoying this more?"

IDENTIFYING PERINATAL DEPRESSION

Screening perinatal patients for mood and anxiety disorders is recommended by the American College of Obstetricians and Gynecologists (ACOG)[7], American Academy of Pediatrics (AAP)[8], and US Preventative Services Task Force (USPSTF)[9]. NC MATTERS recommends screening for perinatal depression at a minimum of 3 time points across pregnancy and postpartum.

1st Trimester	2nd Trimester	3rd Trimester	Postpartum
At initial prenatal visit	Once during 2nd trimester	Once during 3rd trimester	2 weeks postpartum 6 weeks postpartum 6 months postpartum 1 year postpartum

What do I say?

We ask all of our patients to fill out a questionnaire about their emotional well-being because it is very common for mental health to shift during pregnancy. The form doesn't give a diagnosis—it just helps us start a conversation and figure out how we can best support you if you ever want that support. We also have educational materials and resources available, and you're welcome to ask about them anytime—whether or not you feel like sharing anything today.

**This script is just a suggestion and can be adapted as appropriate.*

SCREENING TOOLS

Edinburgh Postnatal Depression Scale (EPDS)[10]

- The gold standard
- 10-item self-report questionnaire
- Includes symptoms of both depression and anxiety
- Designed for the perinatal population
- Scoring
  - >13 positive screen for depression

Available in Spanish and many other languages

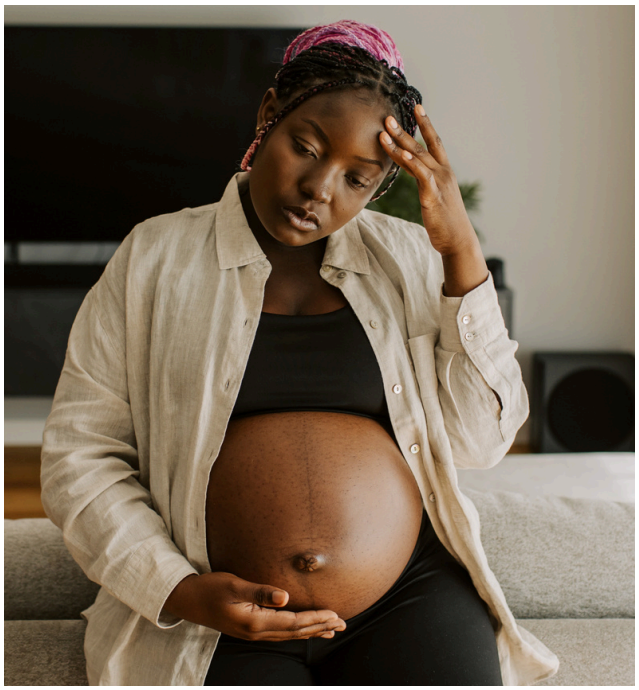
Patient Health Questionnaire 9 (PHQ-9)[11]

- Designed for the general population
- Brief, accessible
- Scoring - response categories are scored 0
  - >10 indicates mild major depression
  - >15 indicates moderate major depression
  - >20 indicates higher severe major depression

Available in Spanish and many other languages

BABY BLUES

Emotional sensitivity, weepiness, and feeling overwhelmed can be normal postpartum.



How does perinatal depression differ from the baby blues?

The "baby blues":[12-14]

- Impacts up to 85% of postpartum people
- Likely associated with the significant changes in hormones in the immediate postpartum period
- Symptoms include weepiness, sadness, mood lability, irritability, and anxiety, but do not seriously impair functioning or include psychotic features
- Resolves without treatment within 2-3 weeks following childbirth

TREATING PERINATAL DEPRESSION[15-17]

Pharmacologic Treatment

Guiding principles for prescribing:

- Use what has previously worked
- Monotherapy is preferable
- Be aware of need to increase dose due to physiological changes of pregnancy

Important points to discuss with patients:

- No psychiatric medication has formal FDA approval for use during pregnancy or lactation
- All psychiatric medications cross the placenta and into breastmilk to some extent
- The risks of exposing the fetus/infant to medication must be balanced with the risks of untreated maternal mental illness
- Infants should be monitored for side effects of medications, especially sedation

Why Timely Treatment Matters

Maternal depression typically does not resolve on its own. Without treatment, it can significantly affect the parent's ability to function and hinder their child's ability to thrive.

Risks to the patient of forgoing timely treatment:

- Persisting or worsening symptoms of depression and anxiety
- Increased mortality and morbidity
- Higher risk of suicide and self-harm
- Poor nutrition and self-care
- Inadequate prenatal care
- Increased risk for both diabetes mellitus and coronary heart disease
- Delusional beliefs and psychotic features

Risks to their child:

- Poor bonding with parent
- Poor family functioning
- Earlier breastfeeding cessation
- Fewer preventative services (e.g., vaccinations)
- Increased risk of child abuse and neglect
- Increased rates of neonatal intensive care unit admission
- Increased cortisol levels at infancy and preschool age

TREATING PERINATAL DEPRESSION, CONT.

Pharmacologic Treatment [17,18]

TYPE	NAME	DOSAGE RANGE	STARTING DOSE	TITRATION INCREMENTS	PREGNANCY / BREASTFEEDING CONSIDERATIONS
SSRIs	Fluoxetine (Prozac)	20-80 mg	10mg or 20mg	10-20mg	• Higher incidence of activating side effects • Has a longer half-life • Higher breast milk transmission
	Sertraline (Zoloft)	50-200mg	12.5 or 25mg	12.5 (for very anxious patients), 25 or 50mg	• Lower breastmilk transmission • Good safety data in pregnancy
	Citalopram (Celexa)	20-40mg	10mg	10-20mg	• Good safety data in pregnancy • Risk of heart arrhythmia • If hepatic impairment, max recommended dose is 20 mg qd
	Escitalopram (Lexapro)	10-20mg	5mg	25mg	• Safety in pregnancy comparable to citalopram
	Paroxetine (Paxil)	20-60mg	10mg	10-20mg	• May increase risk of CV malformations
	Vortioxetine (Trintellex)	10-20mg	10mg	5-10mg	• No large-scale studies or clinical guidelines specifically addressing the safety of vortioxetine in human pregnancy
SNRIs	Venlafaxine (Effexor XR)	75-375mg	37.5mg or 75mg	37.5-75mg	• Less safety data in pregnancy • Avoid in women with hypertensive disorders
	Desvenlafaxine (Pristiq)	50-100mg	25mg	25mg	• Limited safety data in pregnancy, but comparable to venlafaxine
	Duloxetine (Cymbalta)	30-120mg	30mg	30mg	• May also help with comorbid neuropathic pain
NDRI	Buproprion (Wellbutrin IR, SR, XR)	Varies by formulation, typically 100-450mg	Varies by formulation, typically 100-150mg	Varies by formulation, typically 100-150mg	• Helpful for smoking cessation • May be helpful for ADHD

Pharmacologic Treatment, cont.

Atypical	Mirtazapine (Remeron)	15-45mg	7.5 or 15mg	7.5-15mg	• Less safety data in pregnancy • May be helpful with nausea and vomiting in pregnancy
	Trazodone (Desyrel)	50-400mg	25 or 50 mg	25-50mg	• Higher dosages more antidepressant affect

This is not intended to be an exhaustive list of medications. Please call NC MATTERS if you have any questions about prescribing these medications or others that are not listed.

Non-pharmacologic Treatment

Psychotherapy [19-21]	**First line for mild to moderate perinatal depression** • Cognitive Behavioral Therapy (CBT) • Interpersonal Psychotherapy (IPT) • Acceptance and Commitment Therapy (ACT) • Family-Based Therapy • Couples Therapy • Dialectical Behavior Therapy (DBT)
Interventional [22]	Typically used in refractory cases • Electroconvulsive Therapy (ECT) • Transcranial Magnetic Stimulation (TMS)
Supportive Treatments	To complement treatment, not standalone • Sleep protection • Exercise/physical activity • Meditation • Support group • Light therapy

TREATMENT ALGORITHM

Screen using the PHQ-9 or EPDS

YES

Screens positive

NO → Does not meet criteria Repeat screening based on NC MATTERS recommendations

YES

Screens positive for Q10 on EPDS or Q9 on PHQ-9

YES → Perform risk assessment

check out our Suicide and Risk Assessment Toolkit

NO

Medical work-up

Screens positive for mania using Rapid Mood Screener (RMS) or Mood Disorder Questionnaire (MDQ)

NO → Mild depression symptoms **YES** → Therapy

NO → Moderate to severe depression symptoms **YES** → Therapy and start medication

YES

Call NC MATTERS

Seek psychiatric provider assistance

UNSURE? NEED ADDITIONAL SUPPORT?

Is the patient currently taking, or have they previously taken, a medication that was **effective and well tolerated**?

YES → Consider restarting or continuing that medication

NO

History of a family member on medication?

YES

NO → Consider initiating a medication from the table (pg. 4) that is appropriate for this patient

Medical Work-Up

- A focused physical examination may uncover medical causes or contributors to perinatal depression
- Screen for sleep issues; consider a sleep study if there is a concern for sleep apnea
- Consider ordering the following labs if you suspect depression during the perinatal period: Thyroid panel, complete blood count (CBC), vitamin D, vitamin B12, folic acid, comprehensive metabolic panel (CMP), and urinalysis
- Screen for substance use if not completed previously, with consent from the patient
- Depending on neurological exam (e.g., new persistent headaches, visual changes, altered mental status), neuroimaging can be considered

TREATMENT ALGORITHM

For patients

Postpartum Support International

A confidential helpline that provides basic information, support, and resources for pregnant and postpartum individuals

- Call or Text 24/7: 1-800-944-4773
- Text en español: 971-203-7773
- postpartum.net

NC MATTERS - For Dads and Partners

Find resources for dads and partners—learn ways to care for your own well-being, get tips for supporting your partner, and explore tools to help you thrive in parenthood

- https://www.med.unc.edu/ncmatters/for-dads-and-partners/

MGH Center for Women's Mental Health Blog

Blog posts focused on topics related to reproductive and maternal well-being

- womensmentalhealth.org/blog/recent-posts

For clinicians

Free Provider Consultation with NC MATTERS

NC MATTERS is a free consultation service for North Carolina healthcare professionals working with pregnant and postpartum women with mental health concerns. A perinatal psychiatry provider can answer your questions about patient care and help connect you to local resources.

Call
919-681-2909 x 2

Learn more at
ncmatters.org

Information on medication use during pregnancy and infant feeding

Mother to Baby
mothertobaby.org

- English and Spanish language fact sheets summarizing information about common exposures during pregnancy and breast/chest-feeding
- Chat with an exposure expert, enroll your patient in observational studies, or schedule a patient consult

Lactmed
ncbi.nlm.nih.gov/books/NBK501922

- Database which provides evidence-based information on drugs and other chemicals to which a breast/chest-feeding parent may be exposed

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