# Perinatal Depression

Progressive Case Conference

*Facilitator's Guide*

## Contributors

Lucy A. Hutner, MD, Co-Founder and Chief Medical Officer, Phoebe
Sarah M. Nagle-Yang, MD, University of Colorado School of Medicine

## Pre-Assessment Learning

Before you attend the classroom didactics on this module, please review some basic concepts of perinatal depression by viewing the following resources:

Epidemiology, risk factors, and etiology videos
Perinatal Depression: Epidemiology
Perinatal Depression: Risk Factors
Perinatal Depression: Pathophysiology

Screening and diagnosis videos
Screening and Diagnosis 1
Screening and Diagnosis 2
Screening and Diagnosis 3
Screening and Diagnosis 4
Screening and Diagnosis 5

Impact of depression in pregnancy
Perinatal Depression: Impact

## Pre-Assessment Learning Objectives

After reviewing these resources, participants will be able to:
Describe the prevalence of depression in the antenatal and postpartum periods
Select appropriate screening methods for depression in the perinatal population

## Overview

Depression in the perinatal period is a widespread but treatable psychiatric disorder. This module will focus on several facets of depression in both the antenatal and postpartum period. This module examines the epidemiology, risk factors, and etiology of perinatal depression, followed by a discussion of diagnosis and screening issues. This module also discusses the impact of depression on pregnancy, including obstetric and psychiatric outcomes. Last, this module focuses on the postpartum period as a particularly vulnerable time for the development of depression and how the risks might be mitigated.

## Session

Pre-assessment Learning (prior to didactic session)
Group activity with videos: 30 minutes
Applying knowledge to a new case: 10 minutes

## Session Learning Objectives

1. Describe the biological, psychological, and social risk factors for the development of depression in the perinatal period, identifying and comparing possible etiologies
2. Discuss the differential diagnoses of antenatal and postpartum depression
3. Discuss and explain the obstetric and psychiatric impact of depression in the perinatal period, including the potential for increased vulnerability during the postpartum period
4. Discuss a potential treatment approach for perinatal depression, encompassing biological, psychological, and social approaches

## Case Presentation Part 1a: Guided Case Presentation

MR is a 27 year old G3P1 woman with a history of major depressive disorder and childhood trauma, who is currently 33 weeks pregnant, referred to you by her obstetrician after receiving an EPDS score of 22 during a recent prenatal visit. Current symptoms include 6 weeks of worsening mood, irritability, low motivation, poor appetite, poor concentration, restless sleep pattern and increased fatigue. She feels "incapacitated" by everyday life and feels "dark, like living is painful." She endorses feelings of worthlessness and passive death wish. She denies active suicidal ideation, intent or plan.

She has no past suicide attempts or hospitalizations. Her history is significant for mild depressive episodes "on and off" since adolescence, often occurring in the days prior to menses and during major life transitions such as her first year of college and the transition to parenthood with her first child. Her most severe depressive episode occurred after the birth of her daughter 9 years ago. Despite being treated with Zoloft at that time with good effect, she has been anxious during this pregnancy about experiencing another severe episode and has felt "guilty about whether I'm even a good mother."

Family history is notable for bipolar disorder in her mother. Her maternal grandmother also required psychiatric admissions following the birth of two of her four children.

Patient reports a harsh parenting style by her father, and physical abuse by both parents. She is currently estranged from both parents. She also was sexually abused by a male relative from age 10-13. She reports often "feeling alone" throughout her life. She currently lives with her fiancé, who is supportive. She is employed at a computer store as a tech specialist. She has been unable to work due to her depressive symptoms and has exhausted her short-term disability, leading to worry she could lose her job. Her fiancé has been picking up extra shifts at work to compensate financially, which has made her feel more distant from him and more socially isolated given that he is her primary social support.

Observe how the clinician discussed the possibility of the diagnosis of antenatal depression and the results of her EPDS score. Clinical Case 1

## FACILITATOR PAUSES FOR DISCUSSION

## Case Presentation Part 1b: Guided Case Questions

1. What is her diagnosis?
   *Elicit the following:*
   -Criteria for the DSM-5 specifier "with peripartum onset"
   -Current or most recent major depressive episode had onset during pregnancy or in the first 4 weeks postpartum
   -Identify which symptoms are specific to major depression (as opposed to pregnancy itself). Symptoms which overlap with "normal" pregnancy include fatigue, changes in appetite, poor sleep.

2. What risk factors does this patient have for the development of perinatal depression?
   *Elicit the following:*
   -Personal history of major depressive disorder

-Personal history of perinatal depression
-Personal history of mood worsening prior to menses (NOT PMDD as symptoms are not exclusive to pre-menses)
-Family history of mood disorder
-History of trauma
-Social stressors: financial

3. What evidence supports an etiological role for the development of perinatal depression?
*Elicit the following:*
Biological:
-Personal history of major depressive disorder
-Personal history of perinatal depression
-Personal history of mood worsening prior to menses (NOT PMDD as symptoms are not exclusive to pre-menses)
-Poor sleep
-Chronic elevated stress
-Genetics: Family history of mood disorder (including postpartum hospitalization)
-Personal history of trauma
-Hormones of pregnancy (33 weeks pregnant)

Psychological:
-Emotional and physical abuse by both parents
-Experienced harsh parenting style from father
-History of sexual abuse
-Feelings of guilt about being a good mother
-Chronic feelings of isolation
-Feeling distant from her fiancé
-History of depression and anxiety around life transitions (college, parenthood)
-Current estrangement/lack of resolution with relationship with parents

Social:
-Current financial stress
-Current job stress and stress regarding job security
-Feeling distant from her fiancé
-Limited social support/Social Isolation

4. How would you characterize her suicide and infanticide risk?
*Elicit the following:*
-Suicide risk factors: presence of passive suicidal thoughts, feelings of worthlessness, trauma
-Suicide protective factors: no active intent or plan, help-seeking, no previous suicide attempts, supportive partner
-Family history of bipolar disorder is concerning; would need to monitor closely for emergence of manic and/or psychotic symptoms, particularly in the postpartum period
-Infanticide risk: elevated particularly if psychosis emerges

## Case Presentation Part 2: Guided Case Questions

1. What are the obstetric and psychiatric outcomes that the patient is at risk for, given her depression?
*Elicit the following:*
-Prematurity, low birth weight, small for gestational age, pre-eclampsia
-Postpartum depression, elevated suicide/infanticide risk
-Impaired infant attachment
-Neonatal irritability and altered behaviors

-Cognitive and psychiatric impact on offspring

2. How can the psychiatrist counsel the patient to reduce the chance of her depression worsening in the postpartum period?
   *Elicit the following:*
   Biological:
   -Discussion risks/benefits of initiating SSRI
   -Ongoing diagnostic assessment to rule out bipolar diathesis
   -Sleep hygiene strategies
   -Stress management/relaxation techniques
   -Discussion of SSRI use in postpartum period/lactation
   -Mental health-promoting strategies, e.g., moderate exercise (if ok by OB)
   -Discuss warning signs of worsening mood in the postpartum period and/or emergence of postpartum psychosis
   -Discussion of risks of suicide and infanticide
   -Interval monitoring with EPDS

   Psychological:
   -Mindfulness-based interventions
   -Stress management/relaxation techniques
   -Interpersonal psychotherapy (robust evidence base in perinatal depression)
   -Mother/infant dyadic psychotherapy
   -Adult attachment-based psychotherapy
   -Couples therapy

   Social:
   -Focus on increasing social supports
   -Support in postpartum period (e.g. postpartum doula)
   -Discussion of parental leave policy at the workplace and plans for childcare
   -Peer support groups or home visiting programs

Watch how one clinician addressed the diagnosis of perinatal depression and the impact of depression on pregnancy and treatment planning with the patient. Clinical Case 2

## Part 3a: Applying Knowledge to a New Case

RT is a 36-year-old woman, G1P1, currently five weeks postpartum, who presents to her first outpatient psychiatry appointment with depressed mood. She describes low mood with hopelessness, insomnia, irritability, and negative ruminations. She has difficulty initiating sleep (even when her newborn is sleeping) and experiences anxious ruminations about the baby's health. She had previously been stable on a moderate dose of fluoxetine, however at the advice of her family physician she had tapered and discontinued fluoxetine when first trying to conceive this pregnancy. She has a history of SSRI use in the past, including trials of sertraline (felt like a "robot"), citalopram, and fluoxetine. There is no history of suicide attempts or psychiatric hospitalizations. Family history is notable for mother with severe depression and suicide attempt. Patient works as an attorney and is married to a medical resident. Stressors include ventricular septal defect in the neonate, which was repaired after birth. Her older brother died of a medical illness when the patient was eleven years old. She is exclusively breastfeeding her infant.

## Part 3b: New Case Questions

1. What specific risk factors may be contributing to this patient's depression in the postpartum period?
   *Elicit the following:*
   Biological:
   -Postpartum state

-Sleep deprivation
-Anxiety
-Discontinued antidepressant medication
-Family history of depression and suicide attempt

Psychological:
-Anxiety
-Sleep deprivation

Social:
-Medical illness in newborn
-Workload/job expectations for herself and her partner

2. What are some risks associated with postpartum depression?
*Elicit the following:*
-Increased risk of maternal suicide
-Worsening of depression and/or progression to psychotic features
-Impaired parenting practices, such as talking to her infant, reading books to her infant, establishing routines in the home
-Reduced maternal attunement or responsiveness
-Psychopathology in offspring

3. What options might the psychiatrist consider in developing a treatment plan for RT?
*Elicit the following:*
Biological:
-Restarting an antidepressant (may explore her previous responses to other SSRIs with a lower breastmilk concentration and/or shorter half-life as compared to fluoxetine. If other agents have not been efficacious, may consider restarting fluoxetine).
-Prioritizing sleep

Psychological:
-Individual psychotherapy
-Prioritizing sleep

Social:
-Peer support groups
-Increasing social supports

## References

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