Purpose of document: Identification of Perinatal Depression for IMH-HV professionals

**What is Perinatal Depression?**

Perinatal depression is defined in the Diagnostic and Statistic Manual of Mental Disorders, fifth edition (DSM-V) as a Major Depressive Episode that occurs during pregnancy or within four weeks after childbirth. Major depressive disorder occurs in 19% of people, and includes feeling sadness, emptiness, or hopelessness, loss of interest or pleasure in things that were once enjoyed, significant changes (gain or loss) in weight, sleep disturbances (too much or too little), fatigue or loss of energy, psychomotor agitation or retardation (body heaviness), feelings of worthlessness or guilt, difficulty concentrating or making decisions, and recurrent thoughts of suicide or death. Although the DSM-V defines this as occurring during pregnancy or within four weeks of childbirth, professionals frequently debate that perinatal depression may also be diagnosed up until 1 year postpartum or even up remain elevated up to 3 years postpartum ([10.1542/peds.2020-0857](https://doi.org/10.1542/peds.2020-0857)). Symptoms usually last for 2 weeks at a time or longer.

Perinatal Depression is different from the Baby Blues. The baby blues are common-occurring in 85% of people within the first week of delivery, peaking 3-5 days, and resolving 10-12 days post-delivery. These include mood swings of being very happy or very sad and crying unexpectedly.

**What factors predict Perinatal Depression?**

Perinatal depression is influenced by biological, psychological, social, infant, and trauma factors.

Biologically, perinatal people experience significant shifts in hormones across pregnancy, with a rapid drop in estrogen and progesterone immediately following delivery. These sometimes coupled with decreased sleep, and increased stress related to caregiving, can trigger or sustain depression symptoms. Moreover, if a person has a history of sensitivity to normal fluctuations in hormones or depression, they are more likely to experience depression during the perinatal period, and they are likely to have increased symptoms if they experience subsequent pregnancies, particularly if depression remains untreated. Other biological associated risk factors included high risk pregnancies, gestational diabetes, hospitalizations in pregnancy, emergency cesarean sections, and preterm deliveries.

Additionally, what people put in their bodies- from food to mood altering substances influences mood. If individuals smoke cigarettes or use other substances, they are more likely to be experiencing depression in pregnancy. Additionally, eating a balanced diet while exercising and drinking plenty of water provide a healthy body for the parent and baby.

Psychologically if a person has a history of depression, anxiety, trauma or ambivalence about the pregnancy or baby they may be at increased risk for depression. Negative thinking patterns, and difficulties being psychologically flexible can also contribute to depression as pregnancy and postpartum require an ability to adapt to new and constantly changing environments and experiences for the parent and the baby.

Humans are social creatures, and having babies is socially driven. It takes a village to care for infants and for parents, and when perinatal people have other people to care and support them, they and their children thrive. Having a baby also creates significant changes in people’s social structures, and available or lack of available support. People that have limited social support or access to support may also experience symptoms of depression.

As infant mental health professionals we also must consider what is going on with the baby. Infants’ temperament, medical, sleeping or feeding concerns can also predict perinatal depression.

Finally, traumatic experiences influence all of the above categories and commonly predict depression. Traumatic experiences including a medical birth, or relational maltreatment, like interpersonal violence, or emotional abuse, increase the risk for depression.

**How do I identify Perinatal Depression?**

Most guidelines today recommend screening for pregnant and postpartum period within [OB/GYN](https://www.acog.org/programs/perinatal-mental-health/patient-screening) and within [pediatric](https://www.aap.org/en/patient-care/perinatal-mental-health-and-social-support/integrating-postpartum-depression-screening-in-your-practice-in-4-steps/?srsltid=AfmBOoq4BaeE9iOGdEIQj8UGyapVG3kmv18BUchvkaiCRzxwPFjyPjxX) settings. This could easily be applied in IMH-HV settings too. The most frequently used screeners for perinatal depression are the Edinburgh Postnatal Depression Scale (EPDS) and the Patient Health Questionnaire (PHQ). Both screeners provide a severity rating that indicates the level of concern of the symptoms. This score, coupled with clinician’s observations, and assessment can inform the intervention or support that may be best for the patient.

Screeners can be printed and handed to patients, read to patients and the clinician fills them with the patient, or electronically administered often via electronic health records. Organizations and clinicians are encouraged to consider what method works best for their patient population.

Clinicians are encouraged to use their clinical observations, or interactions with patients to inform their clinical decision making. Some behaviors, in addition to the typical symptoms of depression, clinicians may observe include emotional flatness (meaning the facial expression is unchanging or blunted), irritability or quick temper, not interested in or engaging with the baby or other people, difficulty taking care of themselves or the baby (e.g., not caring for their body), and suicidal actions or thoughts.

**Resources:**

<https://www.nimh.nih.gov/health/publications/perinatal-depression>

https://mc3michigan.org/summary-of-emotional-complications-during-pregnancy-and-the-postpartum-period/