INTRODUCTION

In December, 2008, three Nassau County programs partnered to address the needs of new mothers suffering with Perinatal Mood Disorders. We were all committed to advocate for, educate, screen and treat Mood Disorders in mothers and their new families. Our concerns ranged from the seeming paucity of treatment resources for immigrant and non-English speaking mothers to providing tools for clinical and medical practitioners to help identify Perinatal Mood Disorders. Inviting a variety of colleagues to join us, we started to meet to explore the needs of new moms, learn how these needs were currently being addressed and find out if there was sufficient access for professionals, and consumers, to information for current and best practices about interventions.

This new Nassau County Best Practices for the Treatment of Perinatal Mood Disorders Task Force brought together professionals and organizations who were already involved in providing care, or working to provide more care, to this population to discuss: how to define and establish best practices of care; how to disseminate information to consumers, programs and practitioners and how to use this information to advocate for the supports of new families where a mother may be experiencing the serious symptoms associated with PMD. This multi-cultural and multi-disciplinary Task Force met over the course of three years to collect advocacy, education and treatment information to bring to all consumers and providers in Nassau County. Sandy Wolkoff, former Director, Marks Family Right from the Start, 0-3+ Center of North Shore Child & Family Guidance Center, Angeles Davila, Director of the Nassau County Perinatal Services Network, and Sonia Murdock, Executive Director of the Postpartum Resource Center of New York, have led this effort, with the support and wisdom of the
participants listed below. A grant awarded by the Hagedorn Foundation to North Shore
Child & Family Guidance gave us the financial resources to administer this endeavor, but
the generosity of the agencies and individuals of the Task Force made our goals
attainable.

The members of the Task Force struggled with many issues that both expanded our
efforts and caused us to stumble a bit. The enormous need for advocacy efforts for non-
English speaking and minority populations, the importance of presenting important
educational information to consumers and providers alike and the need for training and
practice guidelines for the front line professionals who would need to identify, refer,
and treat women with a range of Perinatal Mood Disorders, gave us a full agenda.

During our meetings we often referred to the Diagnostic and Statistical Manual- IV (R)
for mental illness criteria, the guidelines and information provided by the American
College of Gynecology and Obstetrics and the new surveillance guidelines of the
American Academy of Pediatrics. We reviewed screening protocols and tools from a
number of different sources and started to collect updated information that would be
helpful and user friendly to both consumers and the front line professionals providing
care to them. We worried about reaching consumers and supporting providers by giving
them accessible and accurate information and over time, decided to develop an
electronic collection of information on Perinatal Mood Disorders.

This electronic manual is a step towards making sure that best practice guidelines that
can be used in many different contexts, programs, and services in Nassau County and
assure pregnant women, new mothers, and their families, that good care will be
available to them. We hope you find this manual helpful and use it often.

Sandra R. Wolkoff, LCSW
Acknowledgements

This task force and manual is a result of the close collaboration and contributions of many partners. The work towards the development of a county wide resource and best practices manual could not have taken place without the funding received from the Hagedorn Foundation. In addition, the Nassau County Department of Health’s commitment and key leadership made this Task Force possible. The Nassau County Department of Mental Health contributed time and talent as did so many other individuals and agencies.

MEMBERS - PERINATAL BEST PRACTICES TASK FORCE OF NASSAU COUNTY

Sandra R. Wolkoff, LCSW  (Chairperson) North Shore Child & Family Guidance Center
Angeles Davila, LCSW  (Co-Chairperson) Nassau County Perinatal Services Network
Jessica Coyer  South Nassau Communities Hospital- Dept. Mental Health
Sonia Murdock  Postpartum Resource Center of New York
Loretta Gambino  Winthrop Hospital Home Care
Jodi Glasser  North Shore Child & Family Guidance Center
Carmen Hellers  NCDOH Community Health Worker Program
Kirstin Hotzler-Connors  Nassau County Perinatal Services Network
Diana Johnson  Nassau County Department of Mental Health
Dr. Jack Levine  American Academy of Pediatrics
Beverly Klein  North Shore - LIJ Health System - Glen Cove Hospital
Sherri Williams  Nassau County Perinatal Services Network-Intern
Shelly Schechter  Nassau County Department of Health-Maternal-Child Health
Joemy Soto  North Shore - LIJ Health System
Dr. Tina Walch  Zucker Hillside Hospital
Nancy Berlow, LCSW  Perinatal Specialist
INDEX OF MATERIALS

A- Parent Information

1) Information on Perinatal Mood Disorders and what parents should know
2) Information on resources in Nassau County that would provide clinical, family and educational support
3) Information on access to health care and support programs
4) Information available online

B- Professional Resources

1) Information on Perinatal Mood Disorders
2) Information on clinical protocols for screening tools
3) Decision trees on suggested interventions and triage
4) Information on resources and referrals
5) Literature from the field

C- Appendices

1) Brochures and resources
Resources for Parents
Most new mothers experience some mood swings or anxiety when they bring home the new baby. Commonly termed “baby blues,” these begin within hours or days of the birth. Physical and hormonal changes in your body, emotional factors related to caring for the baby and disrupted routines, and exhaustion contribute to feelings of being sad or overwhelmed. Baby blues may come and go for up to about 4 weeks and then usually disappear.

Some women experience greater symptoms of depression that do not go away. Postpartum depression (PPD) is a serious illness in which the new mother may experience feelings of sadness, anger, irritability, or worthlessness; no energy or motivation; eating too much or too little; sleep problems (beyond the normal baby awakenings); loss of interest in previously enjoyable activities; difficulty concentrating or making decisions; or fear of “going crazy.” She may also show a lack of interest in the baby or have a fear of harming herself or the baby.

Without treatment, a woman with PPD may feel like she is a “bad mother,” and she may think there is no hope.

How do I know if I have PPD?
If you have any of the symptoms listed above, get help right away. Your health care clinician can assess whether your symptoms are serious. He or she may give you a screening test with questions that have been shown to pinpoint PPD. If you don’t have the energy or desire to go for the office visit, tell someone close to you that you need help, and ask the person to call to make an appointment. Be open with the clinician in describing your symptoms.

Will PPD go away on its own?
PPD is a medical condition that involves the brain. Women with PPD often need medication and/or counseling therapy in order to get well. Getting well is important for you and your baby. The first year of life is a time of huge growth; if the mother is unable to interact with her child, there can be delays in language and brain development, problems with bonding and behavior, and increased crying. The sooner PPD is treated, the sooner the baby can have a healthy mom and you can begin to enjoy motherhood.

What does mental health counseling provide?
Talking to a therapist, psychologist, or social worker may help you learn how depression makes you think, feel, and act. You may be able to change the way you respond to depression. For example, the counselor may give you an action plan to work on areas to feel better. The counselor will give you support to reach your goals. This type of talk therapy is called cognitive behavioral therapy or interpersonal therapy and is provided by a licensed mental health specialist.

What kind of medications might help?
Antidepressants are prescription drugs that may help improve your mood, sleep, appetite, and concentration. There are several available, and your clinician will discuss benefits and possible side effects of ones that might be right for you. Some are safe to use with breastfeeding.

What else can I do?
Check out online resources that offer information and support. Some of these include www.postpartum.net and www.womenshealth.gov.
Postpartum Depression: 
Patient Information Sheet

What does postpartum depression feel like?

- “It feels scary.”
- “It feels out of control.”
- “It feels like I’m never going to feel like myself again.”
- “It feels like each day is a hundred hours long.”
- “It feels like no one understands.”
- “It feels like my marriage cannot survive this.”
- “It feels like I’m a bad mother.”
- “It feels like I should never have had this baby.”
- “It feels like if I could only get a good nights sleep, everything would be better.”
- “It feels like I have no patience for anything anymore.”
- “It feels like I’m going crazy.”
- “It feels like I will always feel like this.”

Why did this happen to me?

There is no single cause or reason. PPD is a condition that results from a combination of biologic, hormonal, environmental and psychological factors. It is most often influenced by a number of risk factors, some of which may include: dramatic hormonal changes, unexpected childbirth experience, chronic sleep deprivation, your family’s medical history, your previous experience with depression, (particularly PPD), recent losses, lack of social support, environmental stressors, high-needs infant, perceived loss of control, unsupportive partner, history of abuse. It’s important to note that PPD can strike women with no risk factors, too. It is not fully understood why it happens to some women and not to others, but we do know exactly what to do to treat it. For each woman with PPD, the combination of factors that cause it are unique.

Will this ever go away?

Yes. Postpartum illness is more common than you might think. It is a real medical condition that affects 20% of new mothers. It is not your fault. It did not happen because you are weak, or thinking the wrong things, or because you are not a good mother. PPD is a mood disorder characterized by a cluster of symptoms (which are present most of the time during a period of at least two weeks) which can include: weepiness, irritability, anxiety, sleeplessness, loss of appetite, excessive guilt, difficulty concentrating, obsessive thoughts, panic, feelings of sadness, hopelessness, thoughts about death, general fatigue. These feelings and thoughts — which can make you feel like you are doing something wrong or simply not handling motherhood very well — are symptoms which respond well to treatment.

How do I know if I have postpartum depression or if what I’m feeling is normal?

Trust your instincts. If you think something is wrong, it probably is. That doesn’t mean anything terrible is happening. It may mean you are overwhelmed and overloaded and need some down time so you can get things back on track. It is possible for you to be experiencing what we call Postpartum Stress Syndrome, which is not a clinical depression, but rather an adjustment disorder that is self-limited and responds well to supportive intervention. Baby blues, which is marked by feelings of sadness, fatigue, anxiety, occurs shortly after birth and lasts for a few days to a couple of weeks. Postpartum Stress Syndrome and Postpartum Depression can emerge any time during the first postpartum year. If you notice that you are feeling worse as time goes on, it’s important for you to let someone know how you are feeling. Do not let feelings of guilt or shame or embarrassment get in the way of you doing what you need to do to feel better.

What can I do about it?

First, focus on self-help measures, such as eating nutritiously, even if you’re not hungry; resting as much as you can, even if you can’t sleep; getting out of the house for a walk, even if you don’t feel like moving. Avoid caffeine, alcohol, high fat and sugar foods. Talk to someone you trust about the way you are feeling. Let your doctor know. Let your partner know. Find supportive people who can help you and accept their help. Do not delay getting proper treatment. The longer you wait, the harder it is to treat.
What if I still don’t feel better?

Sometimes, self-help measures are not enough. If symptoms persist for more than two weeks, you should consider seeking professional support. Ask your doctor for the name of a good therapist who specializes in the treatment of women and depression. Often, the combination of therapy and antidepressant medication is the most efficient, effective treatment for PPD.

Is there anything else I can do to help myself feel better?

- You can stop blaming yourself.
- You can stop feeling guilty.
- You can begin to accept that you have an illness that is treatable and take the steps necessary for recovery.
- You can put yourself on top of your list of things to take care of.
- You can ask for help and accept it when it is offered.
- You can try to make time for yourself and do your best not to overload yourself.
- You can give yourself permission to rest, to exercise, to surround yourself with things that feel good.
- You can avoid people and things that make you feel bad.
- You can stay close to those who love you unconditionally.
- You can thank them for their continued support.
- You can accept your feelings, good and bad.
- You can take one day at a time, allow yourself the freedom to make mistakes and you can remind yourself that you will not always feel this way.
- You can understand that the healing process is a slow one and may not move as quickly as you would like.
- You can believe that you will feel better again.

What can my husband do to help?

- He can encourage you to rest as much as possible.
- He can take you seriously and listen to your concerns.
- He can go to the doctor or therapist with you to get more information and support for himself.
- He can help you set limits.
- He can sit with your when you’re feeling bad.
- He can tell you he loves you and remind you that you won’t always feel this way.
- He can reassure you that he’s not going anywhere and he can wait this out as long as it takes.
- He can give you permission to do what you need to do to take care of yourself during this vulnerable time.
- He can continue to take care of himself so he remains strong and supportive.

Please inform your doctor if you do not like the way you are feeling.

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www.postpartumstress.com
Perinatal Mood Disorders are the #1 medical complication related to childbearing. At least 10% of pregnant women will experience depression during pregnancy and up to 20% will experience postpartum depression/anxiety within the first 12 months after having a baby. 1 to 2 women in a 1,000 births will experience postpartum psychosis (hallucinations, paranoia, loss of contact with reality symptoms). Women and families need to know they are not alone, this is not their fault and with help this is a treatable illness.

**Perinatal Depression Resources:**

*Social Support*

The Postpartum Resource Center of New York, Inc. is the self help, 501(c)(3) non profit organization providing emotional support, educational information and healthcare and support group resources to New York State women and their families at risk for or experiencing a perinatal mood and anxiety disorder. Their vision is to have a Perinatal Depression Parent Support Network in every New York State community. Training also available for screening, assessment and treatment and support groups.

1-855-631-0001 Toll Free Statewide Helpline (or 631-422-2255) free and confidential information and healthcare and support group available daily 9am-5pm with additional support from PRC of NY's trained volunteer Moms on Call and Family Telephone Support from 9am-9pm.

www.postpartumNY.org provides 24/7 access to Postpartum Resource Center of New York's Perinatal Mood Disorders Resource Directory available on-line and educational information as well as suggested books and additional internet resources.

The Postpartum Resource Center of New York's Training Institute offers workshops and courses to meet your group's needs in further building a perinatal mood disorders safety net in your community. Trainings include Circle of Caring Pregnancy and Postpartum Depression Support Group replication and Assessment and Treatment of Perinatal Mood Disorders (including screening for perinatal depression).

Postpartum Support International (PSI) www.postpartum.net (800) 944-4PPD
Membership based non profit organization providing world-wide resources with extensive US social support network. Information for healthcare providers and the public. Free weekly educational telephone group sessions available.

Federally Supported
www.mchb.hrsa.gov/pregnancyandbeyond/depression/ HRSA and US Department of Health and Human Services' new site on perinatal depression. Download or order new free booklet Depression During and After Pregnancy: A Resource for Women, Their Families and Friends (also in Spanish)

Books

- Pregnancy Blues by Shaila Misri, MD (The main book for depression during pregnancy)
- The Journey to Parenthood: Myths, Reality and What Really Matters by Diana Lynn Barnes, PsyD and Leigh Balber
- Beyond the Blues: A Guide to Understanding and Treating Prenatal and Postpartum Depression by Shoshana Bennett & Pec Indman (Available in English & Spanish)
- Nobody Told Me: My Battle with Postpartum Obsessive Compulsive Disorder and Postpartum Depression by Wendy Isnardi
- The Stork's Revenge: My Struggles and Triumphs over postpartum depression by Geraldine O'Keeffe
- Postpartum Depression Demystified: An Essential Guide for Understanding and Beating the Most Common Complication After Childbirth by Joyce A. Venis and Suzanne McCloskey
- Postpartum Depression for Dummies by Shoshana Bennett, PhD
- This Isn't What I Expected by Karen Kleiman, MSW and Valerie Raskin, MD
- Mother to Mother Postpartum Depression Support Book by Sandra Poulin
- The Postpartum Husband by Karen Kleiman, MSW
- What Am I Thinking? Having Another Baby After Postpartum Depression by Karen Kleiman, MSW
- A Deeper Shade of Blue: A Woman's Guide to Recognizing and Treating Depression in the Childbearing Years by Ruta Nonacs, MD
- Women's Moods: What Every Woman Must Know About Hormones, the Brain and Emotional Health by Deborah Sichel, MD and Jeanne Watson Driscoll, MS, RN, CS

Of additional interest to healthcare providers

- Postpartum Depression Screening Scale (PDSS) by Cheryl Tatano Beck, DNSc and Robert K. Gable, EdD Available in English and Spanish. To purchase call (800) 648-8857
- DVD – Healthy mom, happy family in English and Spanish from www.postpartum.net
- DVD - Postpartum Couples
- Postpartum Mood and Anxiety Disorders: A Guide by Cheryl Tatano Beck, DNSc and Jeanne Watson Driscoll, MS, RN, CS
- I'm Listening: A Guide to Supporting Postpartum Families by Jane I. Honikman, MS
- Depression in New Mothers: Causes, Consequences and Treatment Alternatives by Kathleen A. Kendall-Tackett
- Postpartum Mood Disorders edited by Laura J. Miller
- Evaluation and Treatment of Postpartum Emotional Disorders by Ann Dunnewold, PhD
- Infanticide: Psychosocial and Legal Perspectives on Mothers Who Kill edited by Margaret G. Spinelli, MD
- Postpartum Depression and Child Development by Lynne Murray and Peter Cooper
- Additional resources listed at www.postpartumNY.org
Recursos Depresión Posparto

El Centro de Recursos Postpartum de Nueva York Perinatal y después del parto:
encontrando la ayuda que usted necesita
Servicio de ayuda: (Hablamos español)
1-855-631-0001 o 631-422-2255 www.postpartumny.org
Usted no está sola. Usted no es culpable. Usted se puede mejorar y sentirse bien con ayuda.

Apoyo de PSI (International Posparto de la Ayuda) para las familias hispano parlantes:
800-944-4773, #1 www.postpartum.net
Llame al número de teléfono gratuito para obtener recursos, apoyo e información gratuita.
Déjenos un mensaje y un voluntario le devolverá la llamada.

MedEdPPD: www.MedEdPPD.org/sp es el sitio de Internet desarrollado bajo el auspicio del
Instituto Nacional para la Salud Mental (NIMH, siglas en inglés del National Institute of Mental
Health) para educar acerca de la depresión posparto (PPD, siglas en inglés de postpartum
depression). En esta sección, Mamás y los demás, contiene información para las mujeres
con depresión posparto, sus familiares y amigos.

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familiares y amigos.

www.womenshealth.gov: Oficina de Salud de las Mujeres del Departamento de Salud y
Servicios Humano

http://familydoctor.org/familydoctor/es/diseases-conditions/postpartum-
depression.html

Medline Plus le ayuda encontrar las respuestas que usted busca en temas de salud.
MedlinePlus ha recopilado la información más confiable proveniente de fuentes autorizadas
tales como la Biblioteca Nacional de Medicina y los Institutos Nacionales de la Salud, así
como otras agencias gubernamentales y organizaciones de servicios para la salud.
MedlinePlus también le ofrece mucha información sobre medicamentos, una enciclopedia
médica ilustrada, programas interactivos para el paciente y las más recientes noticias acerca
de la salud.

Maternal and Child Health Library Biblioteca maternal y de las saludes infantiles - Para
información en español sobre servicios prenatales en tu comunidad, llama al 1-800-504-7081. Para
información en inglés, llama al 1-800-311-BABY o llama a tu Departamento de
Salud estatal o local.

HRSA Depresión Durante y Después del Embarazo
http://mchb.hrsa.gov/pregnancyandbeyond/depressionsp/default.htm
Postpartum Support International

PSI Fact Sheet

Postpartum Support International (PSI) is the world's largest non-profit organization dedicated to helping women suffering from perinatal mood and anxiety disorders, including postpartum depression, the most common complication of childbirth. PSI was founded in 1987 to increase awareness among public and professional communities about the emotional difficulties that women can experience during and after pregnancy. The organization offers support, reliable information, best practice training, and volunteer coordinators in every U.S. state and more than 30 other countries around the world. Working together with volunteers, caring professionals, researchers, legislators and others, PSI is committed to eliminating stigma and ensuring that compassionate and quality care is available to all families. The organization was founded in 1987 in Santa Barbara, California, by Jane Honikman.

Vision
It is the vision of PSI that every woman and family worldwide will have access to information, social support, and informed professional care to deal with mental health issues related to childbearing.

Mission
It is a mission of PSI to promote awareness, prevention and treatment of mental health issues related to childbearing in every country worldwide.

Symptoms of depression and anxiety occur in up to 20% of expectant and new mothers. This means that these emotional symptoms are the most common complication of pregnancy, affecting more than 800,000 women every year in the United States alone. These emotional disorders cover a wide spectrum, including antepartum depression and anxiety, postpartum depression, postpartum anxiety, postpartum obsessive-compulsive disorder, postpartum post-traumatic stress disorder and postpartum psychosis. Yet despite their prevalence, perinatal mood and anxiety disorders are under-detected by health care professionals and many women go without treatment.

PSI’s core objectives are:
- To increase awareness of perinatal mood and anxiety disorders through public and professional education.
- To collaborate with other entities involved in mental health and maternal & child health.
- To influence public policy by advocating for legislation that would support increased research and resources, as well as improved identification of and outcomes for women with perinatal mood and anxiety disorders.
In order to fulfill these objectives, PSI sponsors:

- Support and resource coordinators in all of the U.S. states and resource contacts in other countries who offer support and facilitate connections between families, healthcare providers, resources, and education.
- A warmline, (800) 944-4PPD (4773), which offers support and information to women and their families who are in need, both in English and in Spanish.
- An annual conference to bring together experts and interested parties and review progress in the field.
- A newsletter, PSI News, published quarterly featuring pertinent news articles, PSI member activities, contact information, research information, conference and training information and membership updates.
- A website, www.postpartum.net, featuring information on the causes, symptoms, and treatments, how to find and contact PSI coordinators, how to increase social support, healthcare resources, a book and video section, and an international support group list. Our website also provides information on fundraising and sponsorship opportunities. The website includes a legislative update section which helps keep members informed of pending legislation affecting women’s perinatal mental health issues.
- The most comprehensive and up-to-date trainings on assessment and treatment for healthcare providers.
- PSI is actively involved in the creation, promotion and implementation of legislation promoting perinatal mood disorder research, screening, and treatment on the state and federal level.

PSI as a public and social advocate has been involved in the following:

- Congressional legislation:
  - Melanie Blocker-Stokes Postpartum Depression Research and Care Act. Sponsored by Congressman Bobby Rush (Passed 10/15/07)
  - MOTHERS ACT – proposed federal legislation initiated by Senators Menendez and Durbin (Passed 3/21/2010)
- California: Legislation on Postpartum Mood Disorders authored by Assemblyman Paul Koretz (vetoed by Governor Schwarzenegger).
- New Jersey’s mandatory screening law (Governor Corzine, and Former Governor and State Senate President Richard and Mary Jo Codey)
- Position papers and press releases related to the Andrea Yates retrial
- Partnered with CBS in creating CBS Cares Public Service Announcements about postpartum depression.

To learn more, call PSI at 800-944-4PPD or visit www.postpartum.net.

Find the PSI press kit at http://postpartum.net/News-and-Events/Online-Press-Kit.aspx
Pregnancy and Infant Loss

If you, or someone you know, has experienced a pregnancy or infant loss it is not uncommon for the woman to feel sadness, isolation from others and an inability to manage her emotions.

A pregnancy or infant loss at any gestational age can be an emotionally devastating experience. Although pregnancy loss is more common than most people realize (or talk about), every loss is unique and has its own story. Reactions may vary greatly; and no one has a right to tell you how you should feel after experiencing a loss.

Pregnancy loss can happen at any gestational age in the course of a pregnancy:

- **First trimester losses** (weeks 6-13) are generally referred to as miscarriages.
- **Second trimester losses** (weeks 14-22) may also be called a miscarriage, or late miscarriage, by doctors.
- **Third trimester losses** (weeks 24-40) that occur at a gestational age when the baby would live are considered a stillbirth.

Perinatal bereavement has been considered a trigger for post-partum depression or a perinatal mood disorder. It is important to provide women who have experienced a pregnancy or infant loss, and their partners and other family members (children, grandparents), an opportunity to talk about what they went through. Giving permission to these women and validating that what they experienced is a real loss can be valuable in enabling them to re-engage in their world of family, friends, work and community.

Another group, not often identified as experiencing loss, is women/couples who experience problems getting pregnant (infertility). Repeated failures at conceptions, or miscarriages, are often part of the process in fertility treatment. For many, the real feelings of loss, even in the face of future success, should also be addressed.
Perinatal Loss Resources (con’t.)

These perinatal bereavement and infertility resources are available on Long Island and in the NY area for women and their family members:

www.LongIslandPregnancyandInfantLoss.com
Contact: 516-847-4896

Share Pregnancy and Infant Loss Support, Inc.
www.nationalshare.org
800-821-6819

Pregnancy Loss Support Program (PLSP) of the National Council of Jewish Women NY Section
Support groups and telephone outreach
212-687-5030 ext.28

Guardian Angel Perinatal Support - support groups - St Killian's Church in Farmingdale, NY
www.stkilian.com
516-249-8589

North Shore University Hospital Perinatal Bereavement Support Group
516-562-8415

Resolve - The National Infertility Association
www.resolve.org
703-556-7172

American Fertility Association (AFA)
www.theafa.org
888-917-3777

Prepared by Nancy Berlow, LCSW, Perinatal Loss Specialist
Additional Resources
Internet Resources:
MedEdPPD.org - http://www.mededppd.org/  (adapted from website)
MedEdPPD.org is a professional education, peer-reviewed Web site developed with the support of the National Institute of Mental Health (NIMH). The site has two objectives: first, to further the education of primary care providers (pediatricians, family physicians, obstetricians, psychiatrists, nurses, physician's assistants, nurse practitioners, nurse midwives, social workers) who treat women who have or are at risk for postpartum depression (PPD); and second, to provide information for women with PPD and their friends and family members.

National attention has been given to the need for primary care providers to recognize and manage depression, including PPD. Primary care providers have the most contact with postpartum women. However, providers may not feel prepared to screen, diagnose, treat, and refer women for PPD. Formal education for primary care providers on PPD is inadequate, and few continuing education programs on PPD are available, particularly at low cost.

Studies have shown that healthcare professionals want programs that are current, credible, focused, keep their attention, are easy to use, and are available at convenient times. They also want information that they can use in their practice, such as downloadable teaching tools or treatment protocols. With these considerations in mind, MedEdPPD.org has been designed to provide professionals with the tools to successfully screen, diagnose, treat, refer, and engage women with PPD. These include:

- Educational Modules
- Interactive case studies
- Classic papers and current literature in the field
- Provider tools including diagnostic instruments
- Educational video presentations and discussions
- Comprehensive slide library with downloadable slides
- Resources including relevant associations, Web sites, books, journals, and other sources of further information.

Helpline (631) 422-2255  
Toll free (855) 631-0001  
Hablamos Español

The Postpartum Resource Center of New York, Inc. is a self-help organization established to provide emotional support, educational information and healthcare and support group referrals to mothers suffering from prenatal and postpartum depression (PPD).

Our mission is to serve New York state women and their families at risk for and experiencing prenatal and postpartum depression/psychosis.

**Services We Offer:**
- Telephone Support
- Circle of Caring Support Groups
- Healthcare Referrals
- Educational Pamphlets

Postpartum Resource Center of New York, Inc.'s [Training Institute](http://www.postpartumny.org/):
- Perinatal Mood Disorders: Assessment and Treatment (Based on PSI's curriculum)
- Postpartum Depression Screening Scale
- Postpartum Depression: Not Just the Blues Symptoms, Risks and Support Resources
Additional Internet Resources

• The Online PPD Support Group - www.ppdsupportpage.com

• Postpartum Dads - www.postpartumDADS.org

• The Postpartum Stress Center, LLC - www.postpartumstress.com
  - *The Postpartum Stress* website offers information on perinatal mood disorders, resources for moms and family members, information on websites, referrals and books that will be of help to families and professionals.

• Postpartum Progress - www.postpartumprogress.com

• Health Resources and Services Administration, Maternal and Child Health - www.mchb.hrsa.gov/pregnancyandbeyond/depression

• Text4Baby - www.text4baby.org.
  - The Association of Perinatal Networks of New York, Inc. (APN) and the Nassau County Perinatal Services Network have introduced a new national mobile health initiative, text4baby. Each year in the United States, over 500,000 babies are born prematurely and an estimated 28,000 children die before their first birthday. The goal of Text4Baby is to address a critical national health priority through the use of mobile health technology. Text4baby is a free mobile information service designed to promote healthy birth outcomes among underserved populations. An educational program of the National Healthy Mothers, Healthy Babies Coalition, text4baby will help women have safe and healthy pregnancies by providing them with information they need to give their babies the best possible start in life.
  
  - Pregnant women and new moms are encouraged to sign up for this free service by texting BABY to 511411 (or BEBE for Spanish) and will receive free SMS text messages each week, timed to their due date or baby’s date of birth. These messages focus on a variety of topics critical to maternal and child health and can also connect women to early prenatal care.
  
  - For additional information, please contact the Nassau County Health Department Perinatal Services Network at 516.227.9456 or visit www.text4baby.org.
Local Resources
It's sometimes hard to be a mother, but when the "baby blues" don't go away, it can get even harder...

If you are a new mom and you are worried about how you are feeling, please give us a call. We can help.

The **DIANE GOLDBERG MATERNAL DEPRESSION PROGRAM** helps women who have mood disorders during and after pregnancy, a condition that affects 10-20% of all new mothers. Some signs include:

- Difficulty sleeping or eating
- Trouble taking care of yourself or your baby
- Feeling overwhelmed by your emotions
- Having uncomfortable or scary thoughts

If you or someone you know is experiencing any of these symptoms, we can help.

Our services include:

- Individual, couple and family therapy
- Crisis and psychiatric consultation
- Parent support groups

**THE DIANE GOLDBERG MATERNAL DEPRESSION PROGRAM**

is located at the

Marks Family Right From the Start 0-3+ Center

80 North Service Road, LIE

Manhasset, NY 11030

(516) 484-3174

www.northshorechildguidance.org
Zucker Hillside Hospital

The Scope of Perinatal Psychiatry Services at the Zucker Hillside Hospital

- Patients who are currently treated psychiatrically - who are planning pregnancy
- Pregnant women seeking psychopharmacologic consultation
- Individuals who were not previously in treatment who develop a disorder during pregnancy/after delivery
- Individuals dealing with unexpected pregnancy outcomes, e.g., loss and grief issues
- Obstetric patients with complicated psychosocial issues who are experiencing distress

The Perinatal team at Zucker Hillside Hospital

- Services are provided by a multidisciplinary team who work collaboratively: Psychiatrists, Senior Psychiatry Residents, Nurse Practitioners, Psychologists, and Social Workers
- Interventions provided: initial telephone assessment of acuity, scheduled comprehensive evaluation for medication and therapy, ongoing individual therapy, group therapy, couples therapy and medication management.
- Medicaid, Medicare, and most insurance plans are accepted; a sliding scale fee is available for eligible individuals. To make an appointment call: 516-474-4MOM
- To make an appointment call: **516-474-4MOM**
Resources For Professionals
Perinatal depression encompasses a wide range of mood disorders that can affect a woman during pregnancy and after the birth of her child. It includes prenatal depression, the "baby blues," postpartum depression, and postpartum psychosis.

Pregnant and postpartum women have frequent contact with the healthcare system, yet healthcare providers may not know what questions to ask to determine if women are at risk of or suffering from perinatal depression. This fact sheet provides some indicators you can look for.

**Differential diagnosis:** While many of the symptoms are the same across categories, a woman with postpartum depression experiences these symptoms much more strongly and can be impaired to the point where she is unable to do the things she needs to do every day. Unlike the baby blues, which begin shortly after delivery, and resolve within a couple of weeks, postpartum depression can begin at any time within the first year after giving birth and lasts longer than the blues. While a serious condition, it can be treated successfully with medication and counseling.
# Understanding Maternal Depression

## Table of Types, Prevalence, and Symptoms of Perinatal Depression

<table>
<thead>
<tr>
<th>Types &amp; Prevalence</th>
<th>Symptoms</th>
<th>Time Frame</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prenatal Depression</strong>&lt;br&gt;Prevalence: 10-20% of pregnant women</td>
<td>• Crying or weepiness&lt;br&gt;• Sleep problems (not due to frequent urination)&lt;br&gt;• Fatigue&lt;br&gt;• Appetite disturbance&lt;br&gt;• Mood lability (ups and downs — mom is elated one minute, and crying the next)</td>
<td>— Loss of enjoyment of activities&lt;br&gt;— Anxiety&lt;br&gt;— Poor fetal attachment&lt;br&gt;— Irritability</td>
</tr>
<tr>
<td><strong>“Baby Blues”</strong>&lt;br&gt;Prevalence: As high as 80% of new mothers</td>
<td>• Feeling overwhelmed&lt;br&gt;• Irritability&lt;br&gt;• Frustration&lt;br&gt;• Anxiety&lt;br&gt;• Mood lability (ups and downs — mom is elated one minute, and crying the next)</td>
<td>• Feeling weepy and crying&lt;br&gt;— Feeling overwhelmed&lt;br&gt;— Fatigue&lt;br&gt;— Feelings of inadequacy or guilt&lt;br&gt;— Sleep disturbances (not due to baby's night awakenings)&lt;br&gt;— Appetite disturbances&lt;br&gt;— Irritability&lt;br&gt;— Mood instability&lt;br&gt;— Difficulty concentrating or making decisions&lt;br&gt;— Lack of interest in the baby, family or activities</td>
</tr>
<tr>
<td><strong>Postpartum Depression</strong>&lt;br&gt;Prevalence: 10 - 20% of new mothers</td>
<td>• Frequent episodes of crying or weepiness&lt;br&gt;• Persistent sadness and flat affect (mom won’t smile)&lt;br&gt;• Fatigue&lt;br&gt;• Feelings of inadequacy or guilt&lt;br&gt;• Sleep disturbances (not due to baby’s night awakenings)&lt;br&gt;• Appetite disturbances&lt;br&gt;• Irritability&lt;br&gt;• Mood instability&lt;br&gt;• Overly intense worries about the baby&lt;br&gt;• Difficulty concentrating or making decisions&lt;br&gt;• Lack of interest in the baby, family or activities</td>
<td>• Anxiety may manifest as bizarre thoughts and fears, such as obsessional thoughts of harm to the infant&lt;br&gt;— Poor bonding with baby: No attachment&lt;br&gt;— Feeling overwhelmed&lt;br&gt;— Thoughts of death or suicide&lt;br&gt;— May also present with somatic symptoms, e.g., headaches, chest pains, heart palpitations, numbness and hyperventilation&lt;br&gt;<strong>Time Frame</strong> — If symptoms lasts more that 14 days it is postpartum depression</td>
</tr>
<tr>
<td><strong>Postpartum Psychosis</strong>&lt;br&gt;Prevalence: 1-2 per 1,000 new mothers</td>
<td>• Psychiatric emergency: psychiatric hospitalization necessary&lt;br&gt;— Auditory hallucinations and delusions (often about the baby, and often of a religious nature)&lt;br&gt;— Visual hallucinations (often in the form of seeing or feeling a presence or darkness)&lt;br&gt;— Insomnia&lt;br&gt;— Feeling agitated and angry&lt;br&gt;— Anxiety&lt;br&gt;— Paranoia (a paranoid delusional system may inhibit her from sharing her delusion)</td>
<td>• Delirium (waxing and waning symptomatology: appears normal one moment and is floridly psychotic the next)&lt;br&gt;— Confusion&lt;br&gt;— Mania (hyperactivity, elated mood, restlessness)&lt;br&gt;— Suicidal or homicidal thoughts&lt;br&gt;— Bizarre delusions and commands to harm the infant (not just an obsessional thought)</td>
</tr>
</tbody>
</table>
If the condition is interfering in any way with the woman's ability to do what she needs to do it might be serious. Do not be afraid to ask if the woman has had suicidal ideation or is obsessed with thoughts of harming herself or her baby. A gentle way to ask this is "some women have thoughts of harming themselves or their baby. Does this happen to you?"

Postpartum psychosis usually presents within the first few days to a month after delivery, but can occur anytime during the first year. Symptoms may appear abruptly. This disorder has a 5% suicide rate and a 4% infanticide rate. Postpartum psychosis is a severe but treatable emergency and requires immediate admission to a psychiatric facility, possibly requiring 24-hour observation. If you suspect a woman might be experiencing postpartum psychosis, she must be separated from her infant and provided with immediate assistance. Because of the labile and paranoid quality of the psychosis, a mom can appear normal, but then walk into another room and harm her baby. Arranging for childcare and adult assistance in the home is not enough. An important risk factor for postpartum psychosis is a personal or familial history of bipolar illness (manic depression).

**Risk Factors for perinatal depression:**
Prior episodes of postpartum depression, depression during pregnancy, personal or family history of depression, unplanned pregnancy, complications during pregnancy or childbirth, preterm birth, abrupt weaning, poor support from a partner, being a single parent, having a history of severe PMS, experiencing multiple or stressful life events, social isolation, history of childhood trauma or abuse, and substance abuse.

**Treatment of maternal depression:** The two most common forms of treatment are psychotherapy and medications. The type of treatment will depend on the severity of the depression. If a woman is pregnant, plans on breastfeeding, or is breastfeeding, she needs to consult with a qualified physician who is knowledgeable about the latest research on the teratogenic effects of psychotropic medications. In some cases, it is safer to start or continue a medication during and after the pregnancy rather than risk a relapse. It might be helpful to encourage non-clinical interventions such as rest, exercise, or a change in diet. Encourage her to ask for help when she needs it. It may also be helpful to refer a woman to a support group where she can talk with other women who may be having similar experiences. This will let her know that she is not alone.

**Local Resources:**
Call the state’s Growing-Up Healthy Hotline (1-800-522-5006) for a local mental health provider.

**Crisis situations** Please contact the following local agencies for crisis situations:

**Albany County:**
Albany County Mobile Crisis Unit 518-447-9650

**Rensselaer County:**
Crisis Line of the Crisis Department, Samaritan Hospital 518-271-3540

**Schenectady County:**
Ellis Hospital Mental Health Clinic 518-243-3300

**Other Hotlines:**
Mental Health Association of New York City 1-800-273-TALK (8255)

Hopeline 1-800-SUICIDE (784-2433)

Samaritans Suicide Prevention Center 518-689-4673

**Additional information** on postpartum depression is available from the following organizations:

Maternal Infant Network of the Capital Region www.pregnancyandbabies.org 518-426-1153

Postpartum Resource Center of New York, Inc. www.postpartummy.org or 631-422-2255

Mental Health Association of New York State, Inc. www.mhanys.org or 518-434-0439

Postpartum Support International www.postpartum.net or 805-967-7636

**National Institute of Mental Health** www.nimh.nih.gov or 301-496-9567

The National Women’s Health Information Center www.4woman.gov or 800-994-9662

American Psychological Association www.apa.org or 800-374-2721

American College of Obstetrics and Gynecologists www.acog.com or 800-762-2264
It is very important to treat maternal depression. There is evidence that links untreated maternal depression to detrimental effects on children. They are at higher risk for developing serious developmental, behavioral, and emotional problems. When a depressed mother goes untreated, the whole family is affected, and the quicker the mother gets treatment, the better the prognosis for the entire family.

Information on Screening for Perinatal Depression:

How and Why?
As a healthcare provider, you may be the first to recognize signs of depression. Screening tools can help you introduce the subject of depression and can be incorporated into the battery of questions that are routinely asked at visits. Screening is an easy, quick, and affordable method of identifying women who may be struggling with depression. While there is no "perfect" screening tool, and research is limited on effectiveness, the Edinburgh Postnatal Depression Scale (EPDS), a 10 question self-report test, and the Postpartum Depression Screening Scale (PDSS), a 35-question self-report test, were both created specifically for new mothers and are showing promise in health care settings.

It is important to note that screening does not replace a diagnostic interview, but it can help to identify women who are at risk and in need of further intervention or referral to mental health services.

Barriers to Treatment
Women (and their healthcare team) may not always recognize that the common effects of pregnancy such as fatigue, lack of energy, poor sleep, and loss of appetite can mask depression. Before dismissing these symptoms as normal for new mothers, an effort should be made to assure that additional symptoms indicative of depression are not present. Conversely, some illnesses, such as thyroid malfunction, may mimic depression, and a complete physical exam may be necessary to rule out any medical causes for the symptoms.

A woman who recognizes that she has symptoms of depression may be inhibited by denial, shame, fear, and/or lack of energy from discussing her symptoms with her provider. Women should be encouraged to be open about their feelings, to seek help, and to feel that depression is not shameful and does not make her a bad mother. Many women may delay acknowledging the symptoms of depression or seeking help in hopes that the symptoms will pass with time, not realizing that time may just exacerbate their condition. Women should be informed that treatment is successful with 80 to 90% of patients, and the earlier that treatment is initiated, the quicker the recovery.

While referral resources may not be readily available in all areas, consultation with mental health staff from a local hospital or clinic may provide valuable support and services. Depending on the case, arranging for a therapist or caseworker to check in periodically with the patient might be advisable. Uninsured women or those on Medicaid may have fewer options for selecting a mental health care provider, but County Mental Health Departments will be able to assist with these cases.

Road to Recovery
Successful treatment of maternal depression requires an awareness of how common the disorder is, identifying symptoms accurately, and initiating treatment quickly. Since depression occurs across all age, race, ethnic and economic groups, every new mother should be screened and educated about perinatal depression. Prenatal visits, the postpartum checkup and routine well-baby visits are ideal times for healthcare staff to discuss and look for the signs of depression. If you recognize signs of depression in one of your patients, ask her about them and reassure her that help exists and she is not alone. Your screening and intervention could make all the difference in the world to women experiencing perinatal depression, and to their families.

For more information on depression screening tools, please go to:

www.perinatalweb.org/Foundation/pmdresources.htm#Tools
(includes the EPDS and the Center for Epidemiological Studies-Depression Scale (CES-D))

(describes the Postpartum Depression Screening Scale (PDSS) and how to order it)

www.aafp.org/afp/20020915/1001.html
(describes psychometric properties of various depression screening tools)
Screenings and Evaluations
INTAKE AND INITIAL ASSESSMENT PROTOCOLS FOR PPD

This is a suggested protocol for interventions when receiving referrals for women suspected of having a postpartum (PPD) or perinatal mood disorder (PMD). This outline will identify procedures that begin with first contact or phone call. This is a focused short term guide to help stabilize the mother, engage, educate, and support the family and assure that the mother is moving to a positive attached state with the infant.

The initial phase is focused on assessing and responding to the possibility of immediate danger and to begin to build safe connections between a mother and her baby. The interventions begin with the initial phone call:

A- **Calls for treatment of PPD** are identified as those calls received from mothers who have had a baby within the last 12 months. All PPD referrals and calls should be triaged as EMERGENCIES. The initial phone screening should include:

   1. Assessing for psychosis, suicidal ideation or plan, or thoughts of infanticide through specific questions: are you thinking of hurting yourself or your baby; do you have help and supports in place; what are those supports; are you currently on medications-if yes, who is prescribing them; are you currently receiving help elsewhere; are you able to sleep or eat; have you had previous postpartum mood disorders in the past; are you alone and when will someone else be there;

   2. An appointment should be scheduled within 24 to 48 hours. If there appears to be an obvious serious risk or if there is suspicion of danger, a referral to an immediately available psychiatrist or Emergency Department should be considered. This is also a time to bring in another family member to help with decision making.

B- **Initial intervention** should include spouse, partners or other family members. Co-consultation with psychiatrist may be help for medication trial or validating need for hospitalization.

   1. A current physical is essential, with special attention paid to thyroid functioning. This should be done as quickly as possible and may be required by a psychiatrist before a medication protocol is started.

   2. Careful history taking for previous psychiatric history or medication usage; evidence of trauma, including birth-related trauma (such as
2- Careful history taking for previous psychiatric history or medication usage; evidence of trauma, including birth-related trauma (such as emergency C-section, medical crisis with either the mother or baby, previous loss of child or miscarriage, course of recent pregnancy (ambivalence, high-risk, medication or hospitalization);

3- Depression screen can be used, particularly one designed for perinatal mood disorders, if primary mental health practitioner is not available or to monitor functioning of client.

C- Engagement and stabilization (one to six weeks) should:
   1- Identify the unique constellation of mood disorder (OCD, anxiety, depression);
   2- Help family understand the diagnosis;
   3- May often include telephone support and multiple sessions each week;
   4- Follow up on activities of daily living and parenting;
   5- Monitor maternal response to baby: this should include observations of action and language about baby, looking for signs of distance or closeness and assessing mother’s anxiety about baby. It is not uncommon to see mothers who do not look at, or touch, their baby, during the session. The therapist needs to maintain an alliance with the mother and often needs to explain baby behavior (turning to sound, crying as communication). Mothers in crisis tend to see baby’s fussiness as critical and rejecting of them.
   6- Medication protocol evaluated; screening for danger and risk should continue through each contact. If client is not stabilizing, case review should considered including consultation with treating psychiatrist.

*May be used with attribution to the author

Prepared By: Sandra R. Wolkoff, LCSW-R 12/5/11
Screening Pathways for Perinatal Mood Disorders

Patient presents with signs and symptoms of prenatal or postpartum depression.

Health care clinician evaluates for and treats hypothyroidism or other medical conditions.

If screening score is high, then assessment for diagnosis, treatment or referral to mental health professional is necessary.

Primary care, psychiatric or psycho pharmacological referral needed within 24-48 hours.

Treatment may include psychotherapy and/or medication and psychosocial interventions.

The patient is given additional information regarding postpartum depression and support groups.

Follow up telephone call to the patient in 5-7 days.

Patient presents without signs and symptoms of perinatal depression.

Screening to assess level of depression.

Screener/clinician asks about patient’s intent to harm self, infant or others

If intent is present, immediate referral to emergency care.

Give materials on prenatal/postpartum depression

If screening score is low, then no referral is made.

An appointment for mental health services set up immediately or within 24-48 hours depending on need.
Care Pathways

An algorithm is provided on www.mededppd.org for medical professionals evaluating postpartum women to help determine if their patient has reached a positive or negative outcome since giving birth. The outcome will indicate if the patient should be referred for additional mental health services or put on an antidepressant regimen and monitored.

This printed version of the Care Pathways algorithm is being provided to you by MedEdPPD.org. The Web site version of this algorithm includes links to supportive resources. This information provided in this document and on the Web site is intended only to increase knowledge on perinatal mood disorders. We do not intend to offer medical advice or treatment of any kind. The tools we offer are intended as tools only, the results of which should be confirmed by a qualified healthcare professional. This information is not a replacement for diagnosis or treatment by a qualified healthcare professional. MedEdPPD cannot be responsible for actions taken without professional medical guidance.

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Your client had a baby in the last 4-6 weeks.

Routine postpartum visit or pediatric visit (2 weeks)

Do you, the client, or the partner suspect that the mother has symptoms of depression?

Using clinical assessment and judgment, ask the mother questions to determine:
- affect
- coping
- social support
- maternal-child interaction
- depression symptoms

Specific assessment questions

Ask mother to complete EPDS:
- in privacy
- check if language support needed
- make lead-in statement and offer instructions for completing

Is there a risk of suicide and harm to infant or others, or a positive score on EPDS self-harm item #10?

Result Positive for EPDS Question #10:
Immediately assess further, using Cox questionnaire or another assessment scale
- Implement agency/practice guidelines
- Document evidence in records
- Do not leave client by herself or alone with baby
- Refer for mental health and/or local child protective services
- Engage support system (discuss importance of involving partner, family)
- Decide treatment plan with client

EPDS Score: 4 or Less
Your client does not seem to suffer from postpartum depression. You may ask your client to take this test again at the next visit.

EPDS Score: 5 to 9
Women with this score are at an increased risk for major depression; there is need to be cautious. Educate them about signs of depression, options for treatment and its benefits. They should have access to a blank EPDS or the interactive online version and know that a score of more than 9 warrants an office visit.

EPDS Score: 10 or More
It is very likely that your client is depressed. She needs further evaluation or referral for further evaluation. Use clinical judgment and further diagnostic evaluation in combination with EPDS to plan care. You should discuss the symptoms, diagnosis, and treatment plan with your client and help facilitate timely care. You may also want to provide the patient with a list of suicide prevention hotlines.

Treatment Plan?

Refer for counseling

Antidepressant therapy

Evaluate results of treatment in 2 weeks

Outcome Negative:
Document evidence in medical record. Continue antidepressant 9-12 months after symptoms remitted. Evaluate every 3 months as needed.

Outcome Positive:
Refer for mental health services.

NEG

POS

Result Negative: Routine care

Disclaimer
Information on this website is intended only to increase knowledge of perinatal mood disorders. We do not intend to offer medical advice or treatment of any kind. The tools we offer are intended as tools only, the results of which should be confirmed by a qualified healthcare professional. MedEdPPD cannot be responsible for actions taken without professional medical guidance.
1. Although the EPDS is a useful measure to confirm depressive symptoms in postpartum women, it is only an adjunct to clinical evaluation and is not intended to replace the development of a relationship with the mother. Rather, the EPDS is a way to facilitate communication between women and healthcare professionals and should be supplemented by the professional’s own intuition and clinical knowledge. The best use of this tool is in combination with training in prevention, detection, and treatment of PPD.

2. Assessment Questions
   - How are you doing?
   - Be sure to maintain eye contact with the mother when you ask this question
   - Have you had PPD before?
   - Do you have a history of depression?
   - Are you sleeping okay when your baby sleeps?
   - When the baby cries at night, who gets up?
   - How is your appetite? Are you hungrier or less hungry than usual?
   - Are you experiencing anxiety or panic?
   - Are you afraid to be alone with your baby?
   - Do you feel more irritable or angry than usual?
   - Are you worried about the way you feel right now?
   - What worries you the most about the way you feel?
   - Are you afraid you might lose control?
   - Are you having any scary or unusual thoughts?
   - Do you wonder if you’re a bad mother?
   - If you are breastfeeding, how is that working out?
   - Do you ever have thoughts about hurting yourself?
   - Do you find it hard to make decisions?
   - Does your partner know how you are feeling?
   - How do you feel about taking medication if it helps you feel better?
   - Are there other stressful events that are impacting the way you feel?
   - Is there anything you are afraid to tell me, but think I should know?
   - Are you taking any medications or herbs/natural remedies regularly?

3. If the client does not understand written English, non-English translations of the EPDS are available. To access EPDS in English and Spanish versions please go to our Web version of Care Pathways for links to this resource.

Spanish-language EPDS

There are also many translation and interpretation services available to health care professionals. To get help communicating with your client, you might want to check with the volunteer services department at your organization.

4. Because you have recently had a new baby, we would like to know how you are feeling. Please mark the answer that comes closest to how you have felt during the past several days, not just how you are feeling today. We ask that you be as open and honest as possible when answering these questions. Remember that it is not easy being a new mother, and it is OK to feel unhappy at times.
5. **EPDS Instructions**
   - The EPDS consists of 10 short statements. For each statement, the mother marks which of the 4 possible responses comes closest to how she has been feeling in the previous 7 days.
   - The EPDS can be administered anytime from 0 to 52 weeks after birth.
   - All 10 items on the questionnaire must be completed for a valid score.
   - If at all possible, the mother should complete the scale herself, although she may need assistance if she has limited reading skills or understanding of the English language.
   - Care should be taken to avoid the possibility of the mother discussing her answers with others.

6. **EPDS Question #10 (For any answer except “Never”). Additional information by interview is required for an answer other than 0 (never).**

   One of the criteria for major depression is thoughts that life is not worth living, thoughts of death, or more active thoughts of self-harm. However, the severity of the depression does not always correlate with the intensity of suicidal ideation. For example, some women with very high symptom levels, as indicated by a high EPDS score, commonly have no thoughts of self-harm, while others with scores near the threshold of 10 may have significant suicidal thinking.

   **What You Should Know.** A common myth is that if you inquire about suicidal thoughts, the patient will act upon them. In fact, talking openly about suicidal ideation may be a relief for the patient as it can open the door for a discussion about specific treatment planning to meet her needs. The American Psychiatric Association published Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors, Volume 160, November 2003.

   **What You Should Do Next.** A plan must be made to increase the likelihood that the patient will be safe from harming herself. Based upon the interview assessment of suicidal thinking, the patient can be referred to a mental health facility for further evaluation and treatment. The following suicide prevention hotlines are also resources:

   - **PPDMOMS.org:** 1-800-PPDMOMS
     http://www.1800ppdmoms.org/

   - **National Hopeline Network:** 1-800-784-2433
     http://www.hopeline.com/

   - **National Suicide Prevention Lifeline:** 1-800-273-8255
     http://www.suicidepreventionlifeline.org/

   **Visit our Provider Network Directory to find a healthcare professional near your patient who is knowledgeable about the treatment of postpartum depression.**

   We also recommend that you (with your patient’s consent), or your patient, let someone in her immediate family or a close friend know what she is going through.

   **Tools for Healthcare Providers:**

   - Screening for Suicidal Ideation
   - APA Practice Guidelines on Suicide
   - Read this useful article on suicide among women published in the Journal of American Medical Women’s Association.
   - Follow-up Question Checklist for Suicidality *(Please go to our Web version of Care Pathways for links to these and additional resources.)*
7. For a woman who scores positively on item 10 of the Edinburgh Postnatal Depression Scale (EPDS), John Cox and colleagues created a follow-up questionnaire to further assess for risk to self or others. Please go to our Web version of Care Pathways for links to this resource.

8. Child Protective Services
A specialized part of the child welfare system, Child Protective Services (CPS) focuses on families in which a child has been identified as a victim of or in danger of child abuse or neglect.

Each state has a system to receive and respond to reports of possible child abuse and neglect. State laws require child protective services agencies to do the following:
- take reports from people who believe a child has been abused or neglected
- find out if abuse or neglect has taken place
- ensure that there is a plan in place to keep children safe
- provide services to families to ensure their children’s safety

Professionals and concerned citizens can call statewide hotlines, local child protective services, or law enforcement agencies to share their concerns.

9. Postpartum depression affects mothers and everyone around them. It is important to involve any significant person in the mother’s life in her care. Because definitions of who is “family” vary, this can include parents, children, siblings, members of the extended family (grandparents, aunts/uncles, etc.), and friends, as well as partners and spouses.

Information and resources for family members are available at:
http://www.medepd.org/mothers/family.asp
http://www.postpartum dads.org
http://www.ppd support.org/
http://postpartum.net/resources/

10. Antidepressants are effective for PPD. The first drug of choice is the one to which the patient has responded in the past; if there is no treatment history, a selective serotonin reuptake inhibitor (SSRI), which has a low risk of toxic effects as well as ease of administration, is the first-line treatment. To minimize side effects, half the recommended dose is used initially for 2 days, then increased in small increments as tolerated.

<table>
<thead>
<tr>
<th>Antidepressants</th>
<th>Recommended Dose Range (mg/day)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SSRIs</strong></td>
<td></td>
</tr>
<tr>
<td>Sertraline</td>
<td>50-200</td>
</tr>
<tr>
<td>Paroxetine</td>
<td>20-60</td>
</tr>
<tr>
<td>Fluvoxamine</td>
<td>50-200</td>
</tr>
<tr>
<td>Citalopram</td>
<td>20-40</td>
</tr>
<tr>
<td>Escitalopram</td>
<td>10-20</td>
</tr>
<tr>
<td>Fluoxetine</td>
<td>20-60</td>
</tr>
<tr>
<td><strong>Tricyclic antidepressants</strong></td>
<td></td>
</tr>
<tr>
<td>Nortriptyline</td>
<td>50-150*</td>
</tr>
<tr>
<td>Desipramine</td>
<td>75-300</td>
</tr>
<tr>
<td><strong>Serotonin norepinephrine reuptake inhibitors (SNRIs)</strong></td>
<td></td>
</tr>
<tr>
<td>Venlafaxine</td>
<td>75-300</td>
</tr>
<tr>
<td>Duloxetine</td>
<td>30-60</td>
</tr>
<tr>
<td><strong>Other</strong></td>
<td></td>
</tr>
<tr>
<td>Bupropion</td>
<td>300-450</td>
</tr>
<tr>
<td>Mirtazapine</td>
<td>15-45</td>
</tr>
</tbody>
</table>

*Dose adjusted according to serum level of 50-150 ng/mL 12 hours post-dose.

Additional Information:
A randomized clinical trial used a dosage titration schedule of 25 to 200 mg/day for sertraline and 10 to 150 mg/day for nortriptyline in the 8-week acute phase. Doses were increased according to schedule unless the woman met criteria for remission OR had prohibitive side effects. The doses of sertraline and nortriptyline that were required to achieve remission (a more stringent response criterion than response) are provided in the table below.

Subjects Who Achieved Remission by Dose of Sertraline or Nortriptyline

<table>
<thead>
<tr>
<th>Doses of sertraline, mg/day</th>
<th>&lt; 100</th>
<th>100</th>
<th>125 or 150</th>
<th>200</th>
</tr>
</thead>
<tbody>
<tr>
<td>Remitted by week 8</td>
<td>4%</td>
<td>54%</td>
<td>15%</td>
<td>27%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Doses of nortriptyline, mg/day</th>
<th>&lt; 100</th>
<th>100</th>
<th>125 or 150</th>
</tr>
</thead>
<tbody>
<tr>
<td>Remitted by week 8</td>
<td>61%</td>
<td>25%</td>
<td>14%</td>
</tr>
</tbody>
</table>


11. EPDS Score ≤4
According to this score, your patient is not likely to be suffering from postpartum depression. However, make sure you check item #10 on the EPDS no matter what the total score is, since thoughts of self-harm can occur in some people without significant symptoms of depression. Postpartum depression can develop anytime up to one year after childbirth, and depression can develop at any time during a woman’s life. The EPDS may be administered again to reevaluate your patient’s situation. The EPDS score is a screening measure, and should be followed by a clinical evaluation for women who screen positive.

What You Should Know. It is not uncommon for women to experience mood disorders during pregnancy or postpartum. One out of eight women has depression that interferes with function after birth. These mood disorders may be caused by a variety of factors such as hormonal changes due to childbirth, life stresses, or having a personal history of depression. (http://www.postpartum.net/brief.html) It is important to screen for signs that your patient is overwhelmed, anxious or depressed, and/or functioning poorly after the birth of a baby. Your patient’s mental health is important to her and her family.

What You Should Do Next. Download the EPDS and give it to your patient for her to keep handy for future reference. It is a good idea for her to repeat the questionnaire if she experiences a decline in mood or function. We also recommend that she familiarize herself with postpartum depression by reading this Patient Brochure. It provides general information in a user-friendly format, and is provided for your patient to read and share with others.
12. EPDS Score 5-9
Your patient is not likely to be suffering from postpartum depression because she has not reached the threshold (EPDS=10 to 12) used by most experts. However, women at the higher end of this spectrum may be likely to develop more symptoms and reach this threshold; in which case, they should be monitored. Regardless of the total score, make sure you check item #10 on the EPDS, since thoughts of self-harm can occur in some people without significant symptoms of depression. Postpartum depression can develop anytime up to one year after childbirth, and depression can develop any time during a woman’s life. Education is appropriate, since women in this range may eventually develop postpartum depression. Your patient should take the EPDS again in two to four weeks to determine whether an episode of depression has evolved, or whether symptoms have subsided.

Visit our Provider Network Directory to find a healthcare professional near your patient who is knowledgeable about the treatment of postpartum depression.

What You Should Know. It is not uncommon for women to experience mood disorders during pregnancy or postpartum. One out of eight women has depression that interferes with function after birth. These mood disorders are caused by a variety of factors such as hormonal changes due to childbirth, life stresses, or having a personal history of depression. (http://www.postpartum.net/brief.html). It is important to screen for signs that your patient is overwhelmed, anxious or depressed, and/or functioning poorly after the birth of a baby. Your patient’s mental health is important to her and her family.

There is a wealth of information about postpartum depression.
1. This Patient Brochure provides general information in a user-friendly format, and is provided for your patient to read and share with others.

2. View the MedEdPPD list of classic papers and recent articles related to postpartum depression.

3. For mental health resources, please visit the American Psychiatric Association (APA) at http://www.psych.org/, or the National Institute of Mental Health at http://www.nimh.nih.gov/.

4. There are also well-respected books that deal with the subject of postpartum depression.

What You Should Do Next. Your patient should stay in contact with you to discuss any deterioration in her symptoms, and repeat the EPDS regularly. The MedEdPPD Provider Network Directory contains a list of specialty providers who are knowledgeable about postpartum depression.
13. EPDS Score ≥10

According to this score, it is likely that your patient is suffering from postpartum depression. Make sure you check item #10 on the EPDS no matter what the total score is, since thoughts of self-harm can occur in some people without significant symptoms of depression. Postpartum depression can develop anytime up to one year after childbirth. Your patient should be evaluated for a diagnosis of depression based on DSM-IV criteria.

Visit our Provider Network Directory to find a healthcare professional near your patient who is knowledgeable about the treatment of postpartum depression.

What You Should Know. It is not uncommon for women to experience mood disorders during pregnancy or postpartum. One out of eight women has depression that interferes with function after birth. These mood disorders are caused by a variety of factors such as hormonal changes due to childbirth, life stresses, or having a personal history of depression. (http://www.postpartum.net/brief.html). It is important to screen for signs that your patient is overwhelmed, anxious or depressed and/or functioning poorly after the birth of a baby. Your patient’s mental health is important to her and her family.

Please take a moment to review the following resources. They describe postpartum depression in more detail, discuss treatment options, and provide related information that will help you address this important issue with your patient:

1. This Patient Brochure provides general information in a user-friendly format, and is provided for your patient to read and share with others.

2. View the MedEdPPD list of classic papers and recent articles related to postpartum depression.

3. For mental health resources, please visit the American Psychiatric Association (APA) at: http://www.psych.org/, or the National Institute of Mental Health (NIMH) at: http://www.nimh.nih.gov/.

4. There are also well-respected books that deal with the subject of postpartum depression.

Tools For Healthcare Providers. (Please go to our Web version of Care Pathways for links to these and additional resources.)

DSM-IV (Depression Criteria)
Risk factors for postpartum depression
Resources for multicultural assessment and treatment of depression

14. The following are examples of nationwide suicide prevention hotlines:

National Hopeline Network: 1-800-SUICIDE
http://www.hopeline.com/

National Suicide Prevention Lifeline: 1-800-273-TALK (8255)
http://www.suicidepreventionlifeline.org/

15. When referring a client for mental health services, it is especially beneficial if the provider has undergone special training in postpartum depression treatment. The following resources can help you and your client locate a provider with such training.

MedEdPPD Provider Directory
(http://www.mededppd.org/referral_center.asp)

Postpartum Support International Membership Directory
(http://www.postpartum.net/directory.html)
Edinburgh Postnatal Depression Scale¹ (EPDS)

Name: ______________________________  Address: ______________________________

Your Date of Birth: ____________________  ___________________________

Baby’s Date of Birth: ___________________  Phone: ___________________________

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt IN THE PAST 7 DAYS, not just how you feel today.

Here is an example, already completed.

I have felt happy:
- [ ] Yes, all the time
- [ ] Yes, most of the time  This would mean: “I have felt happy most of the time” during the past week.
- [ ] No, not very often
- [ ] No, not at all

Please complete the other questions in the same way.

In the past 7 days:

1. I have been able to laugh and see the funny side of things
   - [ ] As much as I always could
   - [ ] Not quite so much now
   - [ ] Definitely not so much now
   - [ ] Not at all

2. I have looked forward with enjoyment to things
   - [ ] As much as I ever did
   - [ ] Rather less than I used to
   - [ ] Definitely less than I used to
   - [ ] Hardly at all

3. I have blamed myself unnecessarily when things went wrong
   - [ ] Yes, most of the time
   - [ ] Yes, some of the time
   - [ ] Not very often
   - [ ] No, never

4. I have been anxious or worried for no good reason
   - [ ] No, not at all
   - [ ] Hardly ever
   - [ ] Yes, sometimes
   - [ ] Yes, very often

5. I have felt scared or panicky for no very good reason
   - [ ] Yes, quite a lot
   - [ ] Yes, sometimes
   - [ ] No, not much
   - [ ] No, not at all

6. Things have been getting on top of me
   - [ ] Yes, most of the time I haven’t been able to cope at all
   - [ ] Yes, sometimes I haven’t been coping as well as usual
   - [ ] No, most of the time I have coped quite well
   - [ ] No, I have been coping as well as ever

7. I have been so unhappy that I have had difficulty sleeping
   - [ ] Yes, most of the time
   - [ ] Yes, sometimes
   - [ ] Not very often
   - [ ] No, not at all

8. I have felt sad or miserable
   - [ ] Yes, most of the time
   - [ ] Yes, quite often
   - [ ] Not very often
   - [ ] No, not at all

9. I have been so unhappy that I have been crying
   - [ ] Yes, most of the time
   - [ ] Yes, quite often
   - [ ] Only occasionally
   - [ ] No, never

10. The thought of harming myself has occurred to me
    - [ ] Yes, quite often
    - [ ] Sometimes
    - [ ] Hardly ever
    - [ ] Never

Administered/Reviewed by ______________________________  Date ______________________________


Users may reproduce the scale without further permission providing they respect copyright by quoting the names of the authors, the title and the source of the paper in all reproduced copies.
Edinburgh Postnatal Depression Scale\textsuperscript{1} (EPDS)

Postpartum depression is the most common complication of childbearing.\textsuperscript{2} The 10-question Edinburgh Postnatal Depression Scale (EPDS) is a valuable and efficient way of identifying patients at risk for "perinatal" depression. The EPDS is easy to administer and has proven to be an effective screening tool.

Mothers who score above 13 are likely to be suffering from a depressive illness of varying severity. The EPDS score should not override clinical judgment. A careful clinical assessment should be carried out to confirm the diagnosis. The scale indicates how the mother has felt during the previous week. In doubtful cases it may be useful to repeat the tool after 2 weeks. The scale will not detect mothers with anxiety neuroses, phobias or personality disorders.

Women with postpartum depression need not feel alone. They may find useful information on the web sites of the National Women’s Health Information Center <www.4women.gov> and from groups such as Postpartum Support International <www.chss.iup.edu/postpartum> and Depression after Delivery <www.depressionafterdelivery.com>.

### SCORING

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

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

Maximum score: 30  
Possible Depression: 10 or greater  
Always look at item 10 (suicidal thoughts)

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### Instructions for using the Edinburgh Postnatal Depression Scale:

1. The mother is asked to check the response that comes closest to how she has been feeling in the previous 7 days.

2. All the items must be completed.

3. Care should be taken to avoid the possibility of the mother discussing her answers with others. (Answers come from the mother or pregnant woman.)

4. The mother should complete the scale herself, unless she has limited English or has difficulty with reading.


## Surveillance and Screening of Post-Partum Mood Disorders

### An Optional Tool for Pediatricians

#### Psychosocial Risk Factors
- Poverty
- Maternal chronic illness
- History of depression, anxiety, mood disorder, substance abuse

#### Maternal behavior (observed or expressed by mother, father, grandparents)
- Depressed affect
- Sleeping more or trouble sleeping
- Lack of enjoyment of usual activities/avoidance of usual activities
- Withdrawal from family
- Neglect of newborn or other children
- Questions reflecting self-doubt/severe anxiety
- Inaccurate expectations of behavior and/or development
- Punitive child rearing attitudes or discipline
- Irritable/disruptive in office/frequent visits

#### Infant risk factors
- Prematurity
- Congenital problems
- “Vulnerable child” syndrome

#### Infant behavior
- Decreased activity
- Increased crying
- Poor feeding
- Failure to thrive
- Sleeping problems
- Increased accidents

### PHQ-2 Screening for Depression (Any “Yes” answer is positive)

Over the last 2 weeks, how often have you been bothered by any of the following problems?

1. During the past month, have you often been bothered by feeling down, depressed, or hopeless?  
   - Yes
   - No
   - O  O

2. During the past month, have you often been bothered by little interest or pleasure in doing things?  
   - Yes
   - No
   - O  O

**Bright Futures** recommends screening mothers for post-partum mood disorders. There is no specific mention of the timing. At the first visit and up to 3-6 months seems reasonable. Please remember that post-partum mood disorders can appear up to 12 months after birth.

Prepared by Jack Levine, MD  10/2/2011
Appendices

Brochures and resources
A Resource for Women, Their Families, and Friends
“I have trouble eating and sleeping. I feel lonely, sad, and don’t have the energy to get things done. Sometimes I don’t even want to hold my baby. If this is supposed to be the happiest time of my life, why does everything feel so wrong?”
For many mothers, the experience of pregnancy and childbirth is often followed by sadness, fear, anxiety, and difficulty making decisions. Many women have difficulty finding the energy to care for themselves, their infants, and their families. Some even have feelings about harming themselves and their children.

If this sounds like you or someone you know, there are two important things you should know.

You are not alone.

Help is near.
Did things change after you became pregnant? Are things different than you expected as a new mother? Are you tired, anxious, sad, and confused? This booklet will begin to explain the possible causes for your feelings—and more importantly—how to find the help you need.
Depression during or after pregnancy refers to a broad range of physical and emotional struggles that many women face. You may have heard this called the “Baby Blues,” Postpartum Depression, Maternal Depression, Prenatal Depression, Postnatal Depression, or Perinatal Depression. In this booklet, we will call it Perinatal Depression.

Perinatal Depression can be mild, moderate or severe. It can occur during pregnancy or within a year after the end of your pregnancy. Without treatment, symptoms may last a few weeks, months, or even years. In rare cases, the symptoms are severe and indicate potential danger to the mother and baby. In all cases, help is available.
“Everybody expects me to be the perfect mother, but I just can’t do it. Sometimes I feel like I can’t even care for my baby.”
What Causes Perinatal Depression?

There are a number of reasons why you may get depressed. As a woman, your body undergoes many changes during and after pregnancy. You may experience mood swings. A new baby will change your sleeping schedule and your lifestyle. In addition, there are many pressures to be the perfect mother.

Some women have family members with depression, some women have had depression in their own past, and for some women, the cause is unclear. But for every woman who suffers Perinatal Depression, the causes are as unique as she is.

Perinatal Depression – It’s More Than the Baby Blues

Many new mothers experience the Baby Blues. This is a very common reaction during the first few days after delivery. Symptoms include crying, worrying, sadness, anxiety, mood swings, trouble concentrating, difficulty sleeping, and not feeling yourself.

The Baby Blues is not the same as Perinatal Depression and does not require medical attention. With time, patience, and the support of family and friends, symptoms linked with the Baby Blues will usually disappear within a few days or within 1 to 2 weeks. If they don’t, it may be a sign of a bigger problem, and you should seek medical help.
“I was so excited I decorated the nursery months before the baby arrived. But when she came, it was not a dream. I had no energy to smile or even to cry. I didn’t even want to pick her up. This was not how I thought it was going to be, and I was ashamed of how I felt.”
Who Is at Risk?

Perinatal Depression can affect any woman—regardless of age, race, income, culture, or education. It affects women who breastfeed and those who don’t. It affects women with healthy babies and those whose children are ill. It affects first-time mothers and those with more than one child. It affects women who are married and those who are not. Women who had problems during pregnancy—and those who didn’t—may experience depression. Because Perinatal Depression is a health problem, it is not the fault of any woman.

A family history of depression or bipolar disorder, a history of alcohol or drug abuse, a recent stressful event, relationship or financial problems, or a previous pregnancy with Perinatal Depression increases a woman’s chances of having Perinatal Depression.

Types of Perinatal Depression

Even before the arrival of the baby, some women experience Depression During Pregnancy. Pregnant women commonly face a large number of challenges, including morning sickness, weight gain, and mood swings. Symptoms such as feeling really tired, appetite changes and poor sleep are often dismissed as “just part of pregnancy,” but if the things you do every day are affected, you should consider seeking help. Whether the pregnancy was planned or unexpected, the changes that your body and emotions go through during pregnancy are very real—and so are the risks of Perinatal Depression during this time.
“I just wish that I could laugh and be happy. When will my sadness go away?”
About one in eight women suffers a form of Perinatal Depression known as **Postpartum Depression**. Symptoms can begin at birth or any time in the first year after giving birth.

Common symptoms for perinatal depression include:

- Sad feelings
- Feeling very anxious or worrying too much
- Being irritable or cranky
- Trouble sleeping (even when tired) or sleeping too much
- Trouble concentrating or remembering things
- Trouble making decisions
- Loss of interest in caring for yourself (for example, dressing, bathing, fixing hair)
- Loss of interest in food, or overeating
- Not feeling up to doing everyday tasks
- Frequent crying, even about little things
- Showing too much (or not enough) concern for the baby
- Loss of pleasure or interest in things you used to enjoy (including sex)

A very small number of women (one or two in 1000) suffer a rare and severe form of Perinatal Depression called **Postpartum Psychosis**. Women who have a bipolar disorder or other psychiatric problem may have a higher risk for developing this form of Perinatal Depression. Symptoms of Postpartum Psychosis may include:

- Extreme confusion
- Hopelessness
- Cannot sleep (even when exhausted)
- Refusing to eat
- Distrusting other people
- Seeing things or hearing voices that are not there
- Thoughts of hurting yourself, your baby, or others

If you or someone you know fits this description, please seek medical help immediately. This is a medical emergency requiring **URGENT care**.
Am I a Good Mother?
“I was worried about what would happen if people thought I couldn’t be a good mother. But when I got help, I realized that I was still the one in control.”
How Do I Know if I Have Perinatal Depression?

Only a trained health care or mental health professional can tell you whether you have Perinatal Depression. However, the following checklist can help you know whether you have some of the common symptoms. Mark the box if the statement sounds familiar to you.

During the past week or two –

☐ I have been unable to laugh and see the funny side of things.

☐ I have not looked forward to things I usually enjoy.

☐ I have blamed myself unnecessarily when things went wrong.

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

☐ I have felt scared or panicky for no good reason.

☐ Things have been getting the best of me.

☐ I have been so unhappy that I have had difficulty sleeping.

☐ I have felt sad or miserable.

☐ I have been so unhappy that I have been crying.

☐ The thought of harming myself, my baby, or others has occurred to me.

Did you check more than one box? If so, we encourage you to visit with a trained health care or mental health care professional who can help determine if you are suffering from Perinatal Depression and advise a course of action.

“Some of the symptoms sounded just like me. I knew it was important to talk to my doctor.”
If I Have Perinatal Depression, What Can I Do?

Some women may find it hard talking about Perinatal Depression. They may be unsure if they have it or how to discuss it. They may wish to deal with their problem secretly and hope that it goes away on its own.

These feelings are more common than one would expect. However, every woman must realize that she is not alone. Perinatal Depression affects thousands of women and can be treated successfully. It is possible to feel better. Here are some things that can help.

1. **Lean on Family and Friends**
   There are many ways that family and friends can help you. A few hours of weekly child care can give you a much-needed break. Get help cleaning the house or running errands. When you share your feelings openly with friends and family, it allows them to provide the important support that you need.

2. **Talk to a Health Care Professional**
   Screening for Perinatal Depression should be a routine part of your health care during and after pregnancy. Health care professionals—such as your doctor, your baby’s doctor, a nurse, or other health care provider—are familiar with Perinatal Depression. They know ways to help, and can explain your options to you. An easy way to raise the subject is to bring this booklet with you to the provider’s office. Show the items that you checked and discuss them. Say that you were reading the booklet and some of it sounds familiar to you. If you feel that your provider does not understand what you are going through, please do not give up. There are many excellent providers who do understand Perinatal Depression, who are ready to listen to you, and who can put you on the road to recovery.
“Meeting with my support group is the best part of the week. When I found women going through the same things as me, I didn’t feel so lonely any more. Now we are moving forward together, hand in hand.”
3. **Find a Support Group**
Although you may not know it, there are probably other women in your community suffering from Perinatal Depression. Finding them can give you a chance to learn from others and to share your own feelings. Ask your health care professional how to find and join a support group.

4. **Talk to a Mental Health Care Professional**
Many mental health professionals have special training to help women with Perinatal Depression. They can give you a safe place to express your feelings and help you find the best ways to manage and even get rid of your symptoms. When choosing counselors or other professionals, ask if they have experience in treating Perinatal Depression. They have helped other women with depression and they can help you too!

5. **Focus on Wellness**
An important step toward treating Perinatal Depression is taking care of your body. A healthy diet combined with exercise can help you gain your lost energy and feel strong. Consider these suggestions:

**Food**
- Eat breakfast in the morning to start your day right
- Eat a variety of foods from all food groups, including two servings of fruit and three servings of vegetables each day
- Choose healthy snacks like non-fat milk, yogurt, fruit, and nuts
- Avoid alcohol use
“When my doctor suggested taking medicine, I wasn’t sure. But it turned out to be the best decision for me. I feel so much better now.”
Exercise

- Invite your friends to go on walks in your neighborhood or to the park
- Try a new activity, such as swimming or biking
- Take time to stretch and strengthen your muscles

In addition, by prioritizing the most important things in your life and letting go of what is least important, you can clear your mind to focus on your own health and well-being.

6. Take Medication as Recommended by Your Health Care Provider

Sometimes medications are necessary in the treatment of depression. As with any medications or medical treatment, you should talk to your health care provider about which medication, if any, may be best for you. Become an educated consumer and find out information about treatment options.

Additional information resources are available on page 21 of this booklet.

How Can Perinatal Depression Affect My Baby and My Family?

The symptoms of Perinatal Depression often create a very difficult situation for families. For infants, the effects of Perinatal Depression can be serious. There is a greater chance of babies arriving too small or too early, or having problems in learning and behavior as they grow older. Older children suffer when they lose the attention and support of their mother. Loved ones suffer because they don’t know what to do or how to help. Other family members are often called upon to fill the gap. Because Perinatal Depression affects the entire family, it is critical that family members recognize the symptoms and help their loved one seek help.
“Something wasn’t right in our family. She felt so much sadness instead of joy. Together we decided to get help. Now that I understand what is happening, I can offer her more of the support she needs.”
Advice for Fathers, Family, and Friends

If you know a woman who has the symptoms of Perinatal Depression, this is how you can help.

As a Spouse or Partner:
• Encourage her to seek help. This is the quickest path to recovery.
• Offer support and encouragement. Your positive actions and words can reduce some of her suffering.
• Listen. Her feelings are real. Let her express them to you.
• Allow her to focus on her own needs. Physical and social activities help women suffering from Perinatal Depression feel stronger, more relaxed, and better about themselves.
• Take time for yourself. It is important for spouses and partners to continue with their work, hobbies, and outside relationships.

As a Friend or Family Member:
• Ask the mother how you can help, including baby-sitting and house cleaning.
• Let her know you are there for her, even if she doesn’t like talking.
• Understand that the father may also feel stressed from the changes that come with being a new father or by a partner who is suffering from Perinatal Depression.

Where Can I Get More Information?

There are many excellent resources on Perinatal Depression. At your local public library, you can use the Internet or check out books to get important information. There are telephone hotlines and support services where you can ask questions. Also, your health care provider may have additional resources. The more you understand about Perinatal Depression, the better you will be able to care for yourself and the ones you love. A list of resources is located on page 21.
“I recognized the symptoms and took charge. It was not easy, but with support from my family, friends, and doctors, and drawing on my own personal strength, I overcame Perinatal Depression and today I am moving forward. My family is well. My baby is well. And most importantly, I am well.”
Where Help is Available

Postpartum Support International
Phone: 800-944-4PPD (800-944-4773) / Internet address: http://www.postpartum.net
For information on treatment, support groups and resources in the United States and 25 countries.

Postpartum Education for Parents
Phone: 805-967-7636 / Internet address: http://www.sbpep.org
A 24-hour support line is available for one-to-one support, from basic infant care to the baby blues and other perinatal topics.
(This may be a Long Distance call.)

1-800-311-BABY (1-800-311-2229)
(In Spanish: 800-504-7081)
For information on prenatal services in your community.

Additional Resources

National Mental Health Association
Phone: 800-969-NMHA (800-969-6642) / Internet address: http://www.nmha.org
For information on Perinatal Depression, including a locator to find a mental health center or provider in your area.

SAMHSA National Mental Health Information Center
Phone: 800-789-2647 / Internet address: http://mentalhealth.samhsa.gov
For information on depression, including a locator to find a mental health center in your area.

National Women's Health Information Center
Phone: 800-994-WOMAN (800-994-9662)
Internet address: http://www.4woman.gov or http://www.womenshealth.gov
Frequently asked questions about depression and pregnancy are available on the Web site.

National Institute of Mental Health
Phone: 866-615-6464 / Internet address: http://www.nimh.nih.gov
The Web site has links to health information and research studies on depression.

American College of Obstetricians and Gynecologists (ACOG)
Phone: 800-762-2264 / Internet Address: http://www.acog.org
Resources for you and your health care provider.

Books

Beyond the Blues, by Shoshana S. Bennett and Pec Indman (Moodswing Press, 2006)
Available in Spanish

Beyond the Birth, by Dawn Gruen, Rex Gentry, Abby Meyers, and Sandra Jolley
(Depression After Delivery, 2003)
Books are available online at: http://www.ppmdsupport.com/resource.php
The information in this booklet is not a substitute for personal medical advice, attention, diagnosis or treatment. If you have questions or concerns about your health or the health of your baby, consult your health care professional.
Perinatal Psychiatry Services
At The Zucker Hillside Hospital

Dianna Guerin, LMSW
Tara Mandel, PhD
Bernadette Powis, NPP
Lisa Testa, PhD
Tina Walch, MD
Pauline Walfisch, LCSW

Appointments
To make an appointment for Perinatal Psychiatry Services, please call:
718-470-4MOM.

Fees
Medicaid, Medicare, and most insurance plans are accepted; a sliding scale fee is available for eligible individuals.

Use your smartphone to connect to our video on postpartum blues, or find us on You Tube by searching ‘NSLIJ why am I blue.’ Or visit http://www.northshorelij.com/NSLIJ/media-portal/behavioral-health/why-am-i-blue

Taking Care of Mom
For A Healthy Mom & Healthy Baby
The Scope of Perinatal Psychiatry Services

at The Zucker Hillside Hospital

Historically, women experiencing behavioral health challenges during pregnancy and new motherhood did so in secret. But now, more women are asking for the help they need to overcome a range of psychiatric disorders and raise healthy families.

The treatment offered at the Perinatal Psychiatry Program may benefit a wide range of new or expectant mothers including:

- Women with existing psychiatric disorders and treatment who are
  - Planning pregnancy
  - Seeking one time medication consultation
  - Looking for treatment to maintain stability during pregnancy
- Women struggling with unexpected pregnancy outcomes such as miscarriage
- Moms facing the challenges associated with children born with complex medical issues
- Moms who deliver healthy babies and subsequently develop postpartum depression
- Women who develop psychiatric symptoms during pregnancy
- Pregnant or postpartum women with complicated medical or social issues who are experiencing emotional distress

While nearly 80% of all new moms experience a mild form of depression and anxiety, commonly referred to as “The Baby Blues,” up to 20% of new moms develop a postpartum depression and 3-5% of new moms develop significant anxiety or obsessive symptoms.

Interventions Provided:

- Initial telephone assessment
- Standardized rating scales
- Comprehensive evaluation for medication and therapy
- Brief or long term individual therapy
  - Interpersonal Therapy (IPT)
  - Cognitive Behavioral Therapy (CBT)
  - Supportive Psychotherapy
- Group Therapy
- Marital Therapy / Couples Therapy
- Medication Management
- Parent-Child Bonding Coaching

As an academic site for teaching and training future care providers, we incorporate state of the art treatment and access to the latest advanced care.

In order to provide the best possible patient care, the treatment team may consult with the patient’s Obstetrician, Primary Care Physician, or previous mental health providers. The team welcomes and includes family members or significant others in the treatment process.

If you find that you have questions and concerns:

- before conception as you plan for a new family
- during your pregnancy as your body changes and the baby grows
- or after delivery as you adjust to your new role

Please call 470-4MOM to receive a confidential evaluation and individualized recommendations.
Winthrop University Hospital
Maternal Child Program
Specialty Programs

Winthrop-University Hospital Home Health Agency also offers special programs personalized for you in collaboration with your doctor. These programs combine home healthcare with in-home patient education to help you achieve the greatest benefit from your treatment plan.

- Joint Replacement
- Post-Mastectomy
- Asthma Management Program
- Congestive Heart Failure
- Diabetes Education & Nutritional Support
- COPD
- Wound Care
- Urogynecology/Gynecology
- Telehealth
- Maternity Antepartum/Postpartum
- Pediatrics (Infants to 18 years of age)
- Translation/Interpreter (CyraCom International is a service utilized for language translation accessed through an 800 telephone number)

A list of community/healthcare resources is also available. Winthrop-University Hospital Home Health Agency does not endorse any specific providers.

Benefits of Using Home Healthcare Services

- Support and care at home
- Close communication with your private doctor
- Personalized plan of care
- Assistance with referrals to other organizations and services in your community

To Make You Feel Confident

Winthrop’s Home Health Agency hours of operation are 8:00 AM to 4:00 PM, Monday to Saturday.

Telephone consultation with a registered nurse is available to patients 24 hours a day, seven days a week by calling (516) 663-8000 or by calling (516) 663-0333 and having the operator page the on-call home healthcare nurse.

Winthrop-University Hospital Home Health Agency

- Licensed by the New York State Department of Health
- Certified to participate in the Medicare, Medicaid and Blue Cross programs
- Participates in most managed care and HMO programs
- Accredited by the Joint Commission on Accreditation of Healthcare Organizations
- Our healthcare providers are committed to treating our patients with dignity and respect. Our staff will be sensitive to your cultural, spiritual and ethnic practices.

The Winthrop Home Health Agency
MATERNAL CHILD PROGRAM

The Winthrop Experience...
Bringing the Caring Home.
Caring Comes Home

Winthrop-University Hospital Home Health Agency is especially concerned with the care of mothers and children. While bringing a new baby home can be a joyous occasion, it can also be a time of stress and uncertainty. New mothers may experience unexpected emotional and/or physical difficulties following childbirth.

At Winthrop, we are concerned about how you will manage at home. The services we may provide can help you recuperate after you leave the hospital.

**HOW IT WORKS**

A nurse will interview you and your family during your hospital stay. If you would like home healthcare, services will be arranged upon your discharge. A nurse and/or social worker will arrange to visit you at home with an order from your physician. If you do not request home healthcare, our staff will give you a follow-up telephone call to discuss how you and your baby are doing. We can also provide phone numbers for community resources, referrals and linkages you may want to access.

Patients may also be referred to home healthcare by their own physician after they have left the hospital.

**INSURANCE COVERAGE**

The Agency bills most commercial insurance plans, Medicare and Medicaid. We also offer the option of private pay, a sliding scale of payment or charity care based upon eligibility defined by the Department of Health. We will be happy to investigate your benefit eligibility for you.

**ELIGIBILITY**

All residents of Nassau County who are under the care of a physician may be eligible for services, regardless of age.

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**Could It Be the Baby Blues?**

Many women experience unexpected mood changes after the birth of a child. This may be Baby Blues or Postpartum Mood Disorder.

**Baby Blues** are what some mothers experience one to three days after the delivery of their babies. The blues refer to intermittent moodiness which can last up to two weeks.

**Postpartum Mood Disorder** is similar to the Baby Blues but is more severe and more persistent. The mood lasts throughout the day and for an extended period of time. Symptoms may appear two weeks to one year following birth or after discontinuing breast-feeding.

**SYMPTOMS TO REPORT TO A PHYSICIAN ARE:**

- Frequent crying
- Trouble sleeping (insomnia/excessive sleeping)
- Appetite disturbances (loss of appetite/overeating)
- Anxiety/panic attacks/worrying too much
- Over concern/under concern for the baby
- Feeling overwhelmed/unable to cope
- Irritability/anger
- Loss of interest in things you previously enjoyed
- Obsessive behavior and/or repetitive thinking
- Fear of harming the baby or yourself

If you believe you or anyone else you know is suffering from Postpartum Mood Disorder please consult a physician or healthcare provider.

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**The Following Specialty Services Are Available to You While You Are a Patient of Winthrop-University Hospital Home Health Agency:**

- **POSTPARTUM HOME HEALTHCARE** – A visiting nurse and a medical social worker may provide intermittent care to you and/or your child. Many women experience sadness, isolation, fear and even depression during their pregnancy and after childbirth. Our Agency is here to help.
- **SKILLED NURSING** – Visits are provided on an intermittent basis when necessary to address your specific needs.
- **REHABILITATION SERVICES** – Physical therapists, occupational therapists and speech-language pathologists are available to help you work on restoring your function and independence.
- **MEDICAL SOCIAL SERVICES** – A medical social worker may assist you with social, emotional, personal and financial concerns related to your health and recovery. They may explore entitlements, community resources and other linkages for services.
- **HOME HEALTH AIDE** – Paraprofessional assistance is available if you qualify or as insurance covers. These limited services are for personal care and assistance with activities of daily living.
- **MEDICAL SUPPLIES AND EQUIPMENT** – Arrangements may be made with outside vendors for rental or purchase of equipment and supplies.
- **TELEMONITORING** – This service is available seven days a week. A home monitoring device is installed in your home and connected to your phone jack. The unit measures your weight, heart rate, blood oxygen level and blood pressure. A nurse reviews your values from a remote computer. A call to you and your physician is made when there is a change in your status.
- **INTRAVENTOUS THERAPY (IV)** – Arrangements may be made for therapy at home for antibiotics, pain management, and hydration. A nurse and supplies will be provided as covered by insurance and physician orders.

---

**IF YOU HAVE ANY THOUGHTS of HARMING YOUR BABY or YOURSELF, SEEK HELP IMMEDIATELY. CALL 911 or GO to a LOCAL HOSPITAL.**
Nassau County Department of Health
Family Resource Guide
Mental Health Services (Maternal Depression)
Postpartum Resource Center (24 hours)-631-422-2255
Mental Health HOTLINE.................504-HELP (4357)
North Shore Child & Family Guidance Center
.................................................................626-1971
South Nassau Mental Health Counseling Center
.................................................................377-5400

Parenting
North Shore Child & Family Guidance Center
.................................................................626-1971

Pregnancy Options
Planned Parenthood of Nassau County......750-2500
Spence Chapin...........................................631-979-5863

**Safe Sleep/SIDS**
New York State Center for Sudden Infant Death
(24 hours).......................................................800-336-7437

Social Services
After Hours Emergency (After 5PM)...........572-3143
Customer Service (Commissioner’s Office)...227-7474
General Information..................................227-8519

Day Care.......................................................227-7976
Employment Programs..............................227-7461
Food Stamps................................................227-8523
Medicaid.....................................................227-8000
Public Assistance........................................227-7581

STD/Sexually Transmitted Diseases
Ask Your Health Care Provider

Use this guide to access the care that you and your family need.

Get in touch with important services to help you stay healthy.

If you have any questions about the Nassau County Perinatal Services Network please contact us at 516-227-9456

Funded by:
New York State Department of Health,
Bureau of Women’s Health
2/2010
**Health Care Providers for Pregnant Women**
(Medicaid Providers)
- Mercy Medical Center: 705-1613
- Nassau University Medical Center: 572-5126
- North Shore/LIJ Health System:
  - Glen Cove Hospital: 674-7631
  - Long Island Jewish Medical Center: 470-4400
  - North Shore University Hospital- Great Neck: 622-5148
- NuHealth Family Health Centers:
  - Elmont: 571-8200
  - Freeport-Roosevelt: 571-8600
  - Hempstead: 572-1300
  - New Cassel-Westbury: 571-9500
- Planned Parenthood of Nassau County: 750-2500
- South Nassau Communities Hospital: 255-8400
- Winthrop University Hospital: 663-3010

**Case Management Services for Pregnant Women**
- Community Health Worker Program: Serving Hempstead & Roosevelt: 572-0934
- Healthy Start-Hempstead: 292-9710
- North Shore Child & Family Guidance Center:
  - Good Beginnings for Babies: Serving Westbury: 997-2926
  - Visiting Nurse Association of Long Island: 739-1270

**Adoption**
- Spence Chapin: 631-979-5863

**Alcohol, Drug and Tobacco Treatment Services**
- Nassau County Drug & Alcohol HOTLINE: 481-4000
- Nassau County Drug & Alcohol Screening Intake Referral Service: 227-7007
- New York State Smokers Quit Line: 866-697-8487
- North Shore Child & Family Guidance Center: 626-1971
- North Shore Hospital Drug/HIV: 562-3010
- Oceanside Counseling Center: 766-6283
- Phoenix House: 631-306-5711

**Baby Safe Haven**
- Baby Safe Haven: 877-796-HOPE (4673)

**Baby Supplies**
- AAA Pregnancy Options/Life Center of Long Island: 408-6300
- Ethical Friends of Children: 280-5526
- Lutheran Baby Clothes Layette Program: 483-3240

**Bilingual Services**
- Circulo de la Hispanidad-Hempstead: 292-2433
- Nassau County Coordinating Agency for Spanish Americans (CASA): 572-0750

**Breastfeeding**
- Lactation Resource Center-South Nassau Communities Hospital: 377-5300
- La Leche League: 800-LA-LECHE
- Women, Infants & Children (WIC): 227-9453

**Car Seat Safety**
- Car Seat Safety: 292-7362

**Child Care**
- Child Care Council of Nassau (Day Care): 358-9288
- Nassau County Department of Social Services:
  - Day Care: 227-7976
  - Early Intervention Program (Birth – 3 years): 227-8661

**Children’s Services**
- Family & Children’s Association: 486-7200
- Nassau County Youth Board: 227-7134
- Nassau County Coalition Against Child Abuse and Neglect: 747-2966

**Dental Care for Pregnant Women**
- Ask Your Health Care Provider

**Domestic Violence**
- Nassau County Coalition Against Domestic Violence:
  - HOTLINE (24 Hours): 542-0404
- Circulo de la Hispanidad, Inc./Salva DV Program
  - Spanish speaking HOTLINE (24 Hours): 889-2849
- Long Island Crisis Center HOTLINE (24 Hours): 679-1111
- Rape/Sexual Assault: 222-2293

**Educational Services**
- BOCES/Adult Education Program (GED): 622-6950
- BOCES/Teenage & Parenting Program: 608-6400
- Long Beach Reach for Teens: 889-2332
- Contact Your Local School District

**Employment/Vocationalal Services**
- Economic Opportunity Commission: 292-9710
- Education Assistance Corporation: 539-0150
- Hempstead Works Career Center: 485-5000
- Hicksville Employment Center: 873-5670

**Emergency Housing**
- Nassau County Department of Social Services: 227-8519
- Nassau County Department of Social Services:
  - Emergency Night Services Unit (Weekdays after 5 PM, Weekends & Holidays 24 Hours): 572-3143
- Mommas House: 781-8637
- Regina Residence: 223-7888

**Food and Nutrition Services**
- Cornell Cooperative Extension: Eat Smart NY: 485-9203
- Commodity Supplemental Food Program: 623-4568
- Health & Welfare Council:
  - Food Referral Program: 483-1110
  - Interfaith Nutrition Network (INN)-Soup Kitchens:
    - Freeport, Glen Cove, Hempstead, Hicksville, Long Beach: 486-8506
  - Long Island Council of Churches:
    - Food Pantry: 868-4989
  - Women, Infants & Children (WIC): 227-9453

**Health Insurance**
- Health and Welfare Council/Child and Family Health Plus: 483-1110 x428

**HIV/AIDS**
- AIDS Information: 800-462-6785
- Nassau County Department of Health:
  - HIV Testing & Counseling: 227-9423

**Legal Services**
- Child Support Help Line: 888-208-4485
- Family Court: 571-9033
- Legal Aid Society: 560-6400
- Nassau/Suffolk Law Services: 292-8100
**Servicios de Salud Mental (Depresión Materna)**
Centro de Recursos Para Depresión Después
Del Parto (24 horas)……………………..631-422-2255
Linea de Salud Mental………………..504-HELP (4357)
North Shore Child & Family Guidance Center
………………………………………………..626-1971
Centro de Consejería de Salud Mental de
South Nassau……………………………..377-5400

Destrezas para Padres
North Shore Child & Family Guidance Center
………………………………………………..626-1971

Opciones para el Embarazo
Planned Parenthood of Nassau County……..750-2500
Spence Chapin……………………………..631-979-5863

**Durmiendo Seguro**
Centro del Estado de Nueva York para la Muerte
Súbita de un Infante (24 Horas)……….800-336-7437

Servicios Sociales
Emergencias de Noche-5PM………………572-3143
Linea de Ayuda (Información General)…….227-8519
Servicios para Clientes-
(Oficina del Comisionado)……………….227-7474
Asistencia Publica ………………………..227-7581
Cuidado de Niños ………………………….227-7976
Cupones para Alimentos…………………..227-8523
Medicaid……………………………………227-8000
Programas de Empleo ……………………227-7461

STD/Enfermedades Sexuales Transmitidas
Pregúntele a su Proveedor de Salud

Esta guía puede ayudarle a obtener el cuidado que usted y su familia necesita.

Conectese con servicios importantes que puede ayudarle a mantenerse saludable.

El Departamento de Salud del Condado de Nassau Red de Servicios Prenatal

**Guía de Recursos para Familias**

La Ayuda que usted necesita. El cuidado que usted merece

Funded by:
New York State Department of Health,
Bureau of Women’s Health
2/2010
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<td>Interfaith Nutrition Network (INN)‐Comedor de Beneficencia: Freeport, Glen Cove, Hempstead, Hicksville, Long Beach..........................486-8506</td>
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She’s one smart mom
She’s got text4baby

Text BABY to 511411
Get FREE messages on your cell phone to help you through your pregnancy and your baby’s first year.

text4baby™
text4baby.org

Founding Sponsor:

Johnson & Johnson

Participating carriers include Alltel, Assurance Wireless, AT&T, Boost Mobile, Cellular South, Celcom, Centennial Cellular, Cincinnati Bell, Cricket, Metro PCS, T-Mobile, Sprint, Spirit Wireless, T-Mobile, U.S. Cellular, Verizon Wireless, and Virgin Mobile USA. If you believe you have been charged for text4baby messages in error, please contact your service provider.
Es una mamá inteligente

Utiliza text4baby

Envía BEBE al 511411
Recibe mensajes GRATIS en tu teléfono que te ofrecerán ayuda durante tu embarazo y el primer año de tu bebé.

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Hey Mom, It’s 4U!

Text BABY to 511411

Get FREE tips on your cell phone to help you through your pregnancy and your baby’s first year.

text4baby.org
¡EH MAMÁ, es para ti!

Envía BEBE al 511411

Recibe consejos GRATIS en tu teléfono que te ofrecerán ayuda durante tu embarazo y el primer año de tu bebé.
Postpartum Blues

Linda* had just moved into a house in a new city. Her three-year-old had started nursery school and her six-month-old was a good baby but one who needed to nurse all the time. Linda called our agency to find out if we had any parenting programs for new mothers. She wanted to meet other mothers in the community and felt she could use the support. By the third meeting of this parenting group she looked exhausted and pale, and burst into tears when someone asked her if she was all right.

She did not want to talk in front of the group members, but after the meeting she spoke to the leader saying she had not felt well in months and she was tired all the time. "I yell at my three-year-old all day," she admitted. While she nursed her baby a lot, she didn't play with her. Her own mother tried to help, but Linda felt criticized and hated having to depend on her. Her husband, who came home from work too late to be of much help, was angry with her because nothing seemed to get done in the house.

Things got much better when Linda realized that it was depression that was making her feel so awful, and moved quickly to get the right mental health services for herself and her family. Currently, her children are doing well, and so is she.

Alisha had her baby just six weeks ago. She was weepy all day and had trouble sleeping, but she was even more concerned about how scared she was of taking care of the baby. She had never bathed her son in the little tub on the counter and still refused to stay alone with him.

Alisha had planned and wanted this pregnancy and was surprised by her feelings. She was beginning to believe that she could never really be a good mother and even talked about wanting to place the baby up for adoption.

Her husband and mother told her that she needed help, leaving Alisha feeling even more overwhelmed and ashamed by how badly she was doing. Alisha is moving along, perhaps more slowly than she would like. She began to talk to a social worker about how she was feeling. Her baby is doing well and things look brighter for the future.

At about the same time, we got a call from a father worried that his wife was very depressed. He had a preschooler and his son's teacher had been complaining about the child's behavior.

A phone call from an anxious father is not a common occurrence at our center and he sounded genuinely alarmed. His wife had agreed to come in with him and an appointment was set up for later that week.

Charlotte arrived looking sullen, clearly dragged in by her husband and feeling that the finger was pointed at her for the problems in the family. She had been somewhat depressed when her son was born but had gone back to work fairly quickly.

Charlotte admitted that she hadn't felt well in the hospital just after her second child (now nine months old) was born and she had been placed on an antidepressant.

She never followed up with psychiatric care or mental health treatment and after about three months took herself off the medication. Now, several months later, she was clearly distressed, irritable, tense and overwhelmed.

In addition, her infant had been diagnosed with a serious medical condition. Her days were bound by the constant therapy services for her baby and fighting with her older son. Her nights were spent arguing with

* Names and other identifying information have been changed.
her husband.

+ When it was suggested that maybe her
"postpartum blues" had not
gone away, Charlotte
seemed surprised that it
could last for months. She
came in for counseling
and, after she stopped
blaming herself for the
family's difficulties, was
able to go back on
antidepressant medication.
She was also unhappy in
her community and as she
became stronger moved to
a community she liked. She
currently is able to
recognize the successes in
herself and her son, whose
behavior in the preschool is
now much improved.

These mothers
have many things in
common; the stress of
new motherhood, life
challenges because of
health or financial issues,
a recent move and loss of
emotional supports. But
what they have in common is that they were
all suffering from
depression. For all three
it seemed to start with
the harmless enough
sounding "baby blues".
The blues stayed
however, gripping these
women's lives with
increasing tension.

What are the
baby blues?

Most women who
have had children are
familiar with the "baby
blues," the few hours or
days of weepiness and
fatigue that many
mothers feel right after
the birth of a child. The
exhaustion and
exhilaration of delivery,
the lack of sleep and help,
and the rapid change in
hormones are all factors
that contribute to a new
mother's mood. But
gradually, most new
mothers regain their
strength and their
hormones stabilize. They
start to fall in love with
their new babies and their
mood and energy level
improve. The "baby
blues" usually passes on
its own and -- with some
support, education and
patience -- is forgotten
quickly.

When is it more?

While the "blues"
seem to occur in the first
girls after delivery,
postpartum depression
can emerge several
months after the delivery,
often with an onset at
attention to the emotional
health of new mothers,
but most studies suggest
that between 12% and
16% of women experience
a major depressive episode
(Source: Current
Psychiatry, May 2002)
after the birth of a child,
and a recent carefully
examined survey for a
New York maternity
center brings the number
much closer to 20%
(Source: "Listening to
Mothers: Report of the
First National US Survey
of Women's Childbearing
Experiences"; Maternity
Center Association;
October-2002.) In the
transition into new
parenthood?

The first thing to
know is what depression
looks like. While many of
us think of depression as
sadness and tearfulness, it
can be, and often is,
much more. Agitation
and difficulty sleeping,
tension and extreme
irritability, "cloudy" 
thinking and inability to
make decisions are also
part of the picture of
depression.

Postpartum
women who are depressed
may have trouble loving
their babies and can be
quite critical even when
"baby blues," the few hours or
days of weepiness and
fatigue that many
mothers feel right after
the birth of a child. The
exhaustion and
exhilaration of delivery,
the lack of sleep and help,
and the rapid change in
hormones are all factors
that contribute to a new
mother's mood. But
gradually, most new
mothers regain their
strength and their
hormones stabilize. They
start to fall in love with
their new babies and their
mood and energy level
improve. The "baby
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women who are depressed
may have trouble loving
their babies and can be
quite critical even when
talking about their
newborns. "He is already
so bad and spoiled," and
"She is trying to
manipulate me into
getting what she wants," are
statements parents
have made about their
newborns. Some
women may be extremely
critical of themselves,
thinking they are doing
poorly as mothers and
believe that their babies
won't love them.

Most women
realize that something is
not quite right. They
worry that they are not
feeling they way they are
supposed to feel about
motherhood. They may
be ashamed and isolate
themselves from family
and friends because they
cannot share what they
experiencing.

In addition, some
women with previous
histories of anxiety
disorders can re-
experience their
symptoms or develop
panic attacks. They find
themselves worrying
excessively about their
infants and having
increasing preoccupation
with health, feeding,
sleeping and toileting
issues. What starts as

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**Postpartum Resources...**

Support:
- Postpartum Support International (PSI) 805-967-7636
  www.postpartum.net; Information for healthcare professionals
  and consumers.
- Depression After Delivery (DAD) 800-944-4PPD
  www.depressionafterdelivery.com; Nonprofit organization
  providing support, information and referrals
- Postpartum Resource Center of New York, Inc. 631-422-2255
  www.postpartumNY.org; Provides educational information, and
  healthcare and support group referrals for New York State
  women and families

Books for Consumers:
- *When Words Are Not Enough* by Valerie Raskin, MD, 1997
- *This Isn't What I Expected* by Karen Kleinman, M.S.W. and
  Valerie Raskin, M.D., 1994
- *Mothering the New Mother: Your Postpartum Resource
  Companion* by Sally Placksin, 1994
- *Overcoming Postpartum Depression & Anxiety* by Linda
  Sebastian, 1998
- *Shouldn't I Be Happy: Emotional Problems of Pregnant and
  Postpartum Women* by Shaila Mian, M.D.
motherly concern becomes a rigid cycle of worrying that is exhausting for the mother to maintain.

Who gets it?
There are many factors that need to be considered when trying to diagnose postpartum maternal depression, or figure out who is at risk for having it. While many believe that the dramatically changing hormones following birth are a significant factor, all women who have delivered babies have major shifts in their hormones and most still do not experience depression.

We do know that there are some women who are at greater risk and that there are some life stressors that are significant risk factors.

+ These include:
  + Previous history of depression - postpartum or at an earlier point in life
  + Undiagnosed medical conditions in mother
  + Medical complications in child
  + Chronic sleep deprivation and fatigue
  + Absence of supports, and increased sense of isolation
  + Previous history of trauma and post traumatic stress
  + Presence of mood disorder during pregnancy

Everyone suffers
When someone in a family suffers from a serious emotional difficulty, everyone suffers. And when it is a new mom, having to care for an infant, the consequences affect all family members and can be more dire.

New mothers who feel tired, weepy, irritable, and unloving towards their baby are often ashamed of their thoughts and feelings. While some appear to have lots of energy and seem on top of all their new responsibilities, most depressed mothers are aware of the gap between what they should be feeling, and how they really do feel. Shame and embarrassment lead to isolation, as women find themselves afraid to tell the truth.

New fathers are overwhelmed and scared by how their wives may be feeling and acting. They are often torn between being supportive and being angry and disappointed by the behavior they are witnessing. The stress is enormous on both the mother, who is trying to make sense of her emotions, and on the marriage, where the needs and demands of parenting are overwhelming both partners.

In addition, we have to pay attention to the babies. Infants need their mothers to be responsive and attentive. Postpartum depression can affect how a mother talks to her baby, and how she comforts and plays with him. Babies who grow up with depressed mothers can exhibit emotional and developmental delays, particularly in their language skills. Mothers who are emotionally unavailable make it harder for their children to understand their own feelings and mothers and children may both find themselves in a vicious cycle of unmanageable feelings and difficult behaviors.

It is important for the health of the whole family that a depressed mom gets help quickly.

How to get help
Postpartum depression is a serious medical issue, for mothers and their families, and must be addressed quickly and thoroughly.

It can be treated and there are many ways that women can be helped. The first is to seek a qualified professional to help make the right diagnosis. A front line practitioner in maternal and child health; i.e., social worker, psychologist, obstetrician, nurse or pediatrician, should be the first stop when a woman and her family think something is wrong.

An honest conversation about feelings is essential and a physical exam is usually recommended. Often a consultation with a psychiatrist is necessary to evaluate the need for medication. Many women get better quickly on the right medication and new research is emerging that may answer concerns about using medication for women who are nursing.

There are also many things women, and their families, can do to prevent additional emotional distress.

+ Get help and support. Join a new mothers group, or parenting class at your library, health center, or community center. It's always easier to go through transitions and stressful times in the company of others in the same situation.
+ Take care of yourself. Eating well, sleeping, and easy exercising may not sound like much, but they are all physically and emotionally restorative.
+ Say "no" to extra demands. Maybe you usually have the family over for dinner on Sundays, but now may be the time to pass that off to someone else. If not, order food in and use paper plates.
+ Talk. Talk to your partner, your friends, your parents, your health practitioner. You will be less isolated and ashamed when the thoughts and feelings are not locked inside you. If what you feel or say is worrisome, then your talking will help you get help quickly.
+ Ask for help - not just mental health interventions, but help

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*Figure: Mother and baby*
Concerns for the Baby...

For the past two decades, researchers have recognized that maternal and postpartum depression pose serious risk factors for children and families. There is an increasing awareness of the importance of maternal depression as a factor in infant development and may be related to many speech and language delays, behavioral difficulties, and emotional development. The new brain research on early childhood brain development, focusing heavily on the link between early stimulation and future cognitive success, establishes connections between a parent's ability to create a nurturing environment and their own depression. Access to appropriate treatment can provide dramatic and life saving interventions. Postpartum and maternal depression needs to be addressed as a major factor interfering with a family's ability to develop and function at an optimal level.

Sandra Wolkoff, CSW

And Note...

The Mark's Family Right from the Start 0-3+ Center of North Shore Child and Family Guidance Center; 80 North Service Road-Long Island Expressway; Manhasset, NY 11030
Contact: Sandra Wolkoff, CSW; Director (516) 484-3174
Therapeutic and support services for families with children ages birth to six. Maternal Depression Outreach Project services include: individual, couple and family therapy; crisis and psychiatric consultation and parent support groups.

Nassau County Perinatal Services Network
(516) 572-0954
The Network currently consists of 30 partners who work together to provide services that can include: Linking families to case management programs, arranging appointments for prenatal care, applying for assistance through programs such as WIC, locating child care programs, supplying food vouchers, and giving health education. Some partners provide multi-lingual services.

Suffolk County Perinatal Coalition, Inc.
(631) 475-5400
This coalition seeks to improve birth outcomes through outreach, case management, and referral services. Pregnant women can receive a mentor to help them through their pregnancy and pregnant women can receive supplies at the "Baby's Dresser" where gently used baby items are available. Help with applying for Child/Family Health Plus is offered onsite.

National Association of Mother's Centers
(516) 520-2929
This organization offers support and discussion groups for new mothers and their babies. Offered at different meeting sites throughout New York. Contact Linda L. Juergans.

F.Y.I.

Lower-income parents are more likely to have higher rates of mental health issues. A recent study of 13 states found that 28% of children in low-income families lived with a parent with symptoms suggestive of poor mental health compared with 17% of children overall.

Untreated maternal depression is disproportionately prevalent among low-income mothers.

This Special Edition of the Parent & preschooler Newsletter is funded by the September 11th Children's Fund.
Tristeza Post Parto

Linda acababa de mudarse a una casa en una ciudad nueva. Su niño de tres años había empezado la preescuela y su niño de seis meses era un buen bebé pero necesitaba que le dieran pecho todo el tiempo. Linda llamó a nuestra agencia para averiguar si teníamos programas para nuevas madres. Quería conocer otras madres de la comunidad y sentir que podía usar la ayuda. En la tercera reunión de este grupo de padres ella se veía agotada y palpita y se puso a llorar cuando alguien le preguntó si estaba bien.

Ella no quería hablar en frente de los miembros del grupo, pero después de la reunión habló con el líder del grupo y le dijo que no se había sentido bien en meses y que siempre estaba cansada. "Le grito a mi niña de tres años todo el día", reconoció. A pesar de que le daba mucho pecho a su bebé, no jugaba con ella. Su propia madre intentó ayudar, pero Linda se sentía críticada y odiada por tener que depender de ella. Su marido, que llegaba a la casa del trabajo demasiado tarde como para poder ayudar en algo, estaba enojado con ella porque nadie hacía el trabajo doméstico.

*Las cosas mejoraron cuando Linda se dio cuenta que era depresión lo que la hacía sentir tan mal, y se movió rápidamente para obtener el servicio de salud mental para ella y su familia. Actualmente, sus niños y ella están bien.*

Alicia tuvo su bebé solo hace seis semanas. Ella sollozaba todo el día y tenía problemas en conciliar el sueño, pero estaba más preocupada sobre cuán asustada estaba en cuanto a poder cuidar de su bebé. Ella nunca había bañado a su hijo en la pequeña tina que tenía sobre el mueble y todavía se negaba a quedarse sola con él.

Alicia había planificado y deseado este embarazo y estaba sorprendida por sus sentimientos. Estaba empezando a creer que ella nunca realmente podría ser una buena madre e incluso habló sobre entregar el bebé para su adopción.

Su marido y madre le dieron que necesitaba ayuda, lo que hizo a Alicia sentirse más abrumada y avergonzada sobre lo mal que lo estaba haciendo.

*Alicia está progresando, aunque un poco más lento de lo que ella deseaba. Empieza a conversar con una trabajadora social sobre las cosas que siente. Su bebé está bien y las cosas se ven favorables en el futuro.*

Casi al mismo tiempo recibimos una llamada de un padre preocupado porque su esposa estaba muy depresiva. Ella tenía un niño preescolar y la profesora de su hijo había estado quejándose sobre la conducta del niño.

Una llamada de un padre angustiado no es una cosa común en nuestro centro y él parecía genuinamente alarmado. Su esposa había acordado e venir con él y se había concertado una cita para los próximos días.

Carla llegó con aspecto respetado, francamente obligada a venir por su marido y sintiendo que todos le echaban la culpa por los problemas de la familia. Ella había estado levemente deprimida cuando había nacido su hijo pero había vuelto al trabajo bastante rápidamente. Carla reconoció que no se había sentido bien en el hospital después de que su segundo niño (que ahora tenía nueve meses) había nacido y se le había administrado un medicamento antidepresivo.

Ella nunca hizo un seguimiento con atención psiquiátrica o terapia de salud mental y después de tres meses dejó de tomar su medicamento. Ahora, varios meses después, estaba claramente alterada, inquieto, tenso y abrumada.

Además, su bebé había sido diagnosticado con una seria condición médica. Sus días estaban consumidos por constantes terapias para su...
bebé y por peleas con su hijo mayor. En la noche se la pasaba alegando con su marido.

*Cuando se sugirió que quizás su “tristeza post parto” no había desaparecido, Carla parecía sorprendida que pudiera durar meses. Vino a la terapia y, después de que dejó de culparse a sí misma por la dificultad de la familia, pudo volver a tomar los medicamentos antidepresivos. Ella también estaba infeliz en su trabajo y a medida que recuperó la fuerza ella se mudó a un suburbio que le gustaba. Actualmente es capaz de reconocer sus éxitos y los de su hijo, esta conducta en la escuela ha mejorado bastante.

Estas madres tienen muchas cosas en común: el estrés de ser nuevas madres, desafíos de la vida por problemas de salud o de dinero, una mudanza reciente y la pérdida de soporte emocional. Pero lo que más tienen en común es que todas estaban sufriendo depresión. Para las tres todo pareció empezar con lo que se llama indudablemente “tristeza del bebé” (“baby blues”). Sin embargo, la tristeza no desapareció, atrapando las vidas de estas mujeres con más tensión.

¿Qué es la tristeza del bebé?

La mayoría de las mujeres que han tenido niños reconocen la “tristeza del bebé”, las pocas horas o días de soledad y fatiga que muchas madres sufren después del nacimiento de un bebé. La fatiga y la euforia del parto, la falta de sueño y de ayuda, y el rápido cambio en hormonas son todos factores que contribuyen al estado de ánimo de la nueva madre.

Pero paulatinamente, la mayoría de las nuevas madres recuperan sus fuerzas y sus hormonas se estabilizan. Empiezan a enamorarse de su nuevo bebés y su anímico y nivel de energía mejoran. La tristeza generalmente desaparece sola y –con apoyo, educación y paciencia– se olvida rápidamente.

¿Cuando es algo más que eso?

A pesar de que lo tristeza parece ocurrir en los primeros días después del parto, la depresión post parto puede aparecer varios meses después del parto, frecuentemente con una presentación de aproximadamente alrededor de dos meses después del nacimiento. Muchas mujeres pueden describirse a sí mismas como sintiendo pésimas desde los primeros días después del parto, pero otras madres describen un aumento de tristeza e irritabilidad a medida que pasan las semanas. La mayoría de las mujeres no se dan cuenta de que están en alto riesgo de depresión en el período post parto. Ella cree que las cosas supuestamente deben estar mejorando, así que ¿quién se está sintiendo peor?

Están surgiendo nuevas estadísticas a medida que los investigadores empiezan a prestar más atención a la salud emocional de las nuevas madres, sin embargo la mayoría de los estudios sugieren que entre el 12% y 16% de las mujeres experimentan un episodio importante de depresión (Fuente: Current Psychiatry, May 2002) después del nacimiento de un niño, y una reciente encuesta cuidadosamente diseñada para un centro materno de Nueva York arroja una cifra más cerca al 20% (Fuente: “Listening to Mothers: Report of the First National US Survey of Women’s Childbearing Experiences;” Maternity Center Association: October - 2002). Entre las posibilidades más alarmantes, una o dos de cada 1,000 mujeres que han tenido hijos tendrán un episodio sícário, caracterizado por conductas y pensamientos anómalos y peligrosos, durante los primeros dos meses después del parto (Fuente: Zero to Three, June/July, 2002).

¿Cómo es la depresión?

Si tu (o alguien que conoces) acaba de tener un bebé, qué debes saber para poder enfrentar con seguridad y felicidad la transición a ser padre?

La primera cosa que hay que saber es cómo es la depresión. A pesar de que muchos de nosotros creemos que la depresión es tristeza y llantos, puede ser, y muchas veces lo es, mucho más. La agitación y problemas del sueño, tensión y excesiva irritabilidad, pensamiento “confuso” y la incapacidad de tomar decisiones también son parte del cuadro depresivo.

Las mujeres post parto que están depresivas pueden tener problemas de querer a sus bebés y pueden ser muy críticas aun cuando hablan sobre sus recién nacidos. “Ya está tan malo y consentido”, y “Ella trata de manipularme para conseguir lo que quiere”, son afirmaciones que han hecho los padres sobre bebés de ocho semanas. Algunas mujeres son extremadamente críticas de sí mismas, pensando que no están haciendo un buen papel de madre y creen que sus bebés no las amarán.

La mayoría de las mujeres se dan cuenta que algo no anda bien. Se preocupan que no estén sintiendo lo que debieran sentir sobre la maternidad. Pueden estar avergonzadas y se aíslan de la familia y amigos porque no pueden compartir lo que están sintiendo.

Además, algunas mujeres con historial previo de desórdenes de ansiedad pueden reexperimentar sus síntomas o desarrollar ataques de pánico. Se encuentran preocupándose excesivamente sobre sus bebés y además tienen un aumento de preocupación por la salud, alimentación, sueño y los problemas de higiene. Lo que empieza como preocupaciones maternales se convierte en un ciclo rígido de preocupación que es extenuante para la madre.

¿A quién le da?

Hay muchos factores que deben tomarse en cuenta cuando se trata de diagnosticar la depresión maternal post parto, o saber quién está a riesgo de adquirirla. Mientras que muchos creen que los cambios dramáticos en las hormonas después del parto son un factor importante, todas las mujeres que han tenido bebés tienen cambios importantes en sus hormonas y la mayoría de
ellas no experimentan depresión.

Si sabemos que hay algunas mujeres que están a más riesgo y que hay algunos estreses que son importantes factores de riesgo.

Estos incluyen:
* Historial previo de depresión —post parto o en algún momento previo de la vida.
* Una condición médica no diagnosticada en la madre.
* Falta de sueño y fatiga crónica.
* Falta de apoyo y un aumento de la sensación de aislamiento.
* Historial de trauma y estrés post-traumático previo.
* La presencia de un desorden de ánimo durante el embarazo.

**Todos sufren**

Cuando alguien en la familia sufre de una dificultad emocional sería todos sufren. Y cuando es una nueva madre, que tiene que cuidar un bebé, las consecuencias afectan a todos los miembros de la familia y pueden ser más serias.

Las nuevas madres que se sienten cansadas, con ganas de llorar, irritables, y que no sienten amor hacia su bebé generalmente están avergonzadas de sus pensamientos y sentimientos. Mientras que algunas parecen tener mucha energía y parecen manejar todas sus nuevas responsabilidades, la mayoría de las madres están conscientes de la brecha entre lo que deben estar sintiendo y lo que realmente sienten. La vergüenza y bochorno conducen al aislamiento, a medida que las mujeres tienen miedo de decir la verdad.

Los nuevos padres están abrumados y asustados por lo que sus esposas pueden estar sintiendo o haciendo. A menudo sienten la contradicción entre apoyar y estar enojados y desilusionados por la conducta que están presenciando. El estrés es enorme en la madre, que está tratando de comprender sus emociones, y en el matrimonio, donde las necesidades y demandas de ser padres son abrumadoras en ambos cónyuges.

Además, tenemos que prestar atención a los bebés. Los bebés necesitan que sus madres les presten atención y que respondan. La depresión post-parto puede afectar la manera en que la madre le habla a su bebé, y como lo consuela y juega con él. Los bebés que se sientan con madres dramatizadas pueden presentar retrasos emocionales y de desarrollo, especialmente en sus destrezas del lenguaje. La madre que no está disponible emocionalmente hacen que sea más difícil que sus niños entiendan sus propios sentimientos, y las madres y los niños pueden encontrarse en círculos viciosos de sentimientos inmanejables y conductas difíciles.

Es importante para la salud de toda la familia que una mamá deprimente reciba ayuda rápidamente.

**Cómo obtener ayuda**

La depresión post parto es un problema médico serio, para las madres y sus familias, y tiene que ser abordado rápida e integralmente.

Puede ser tratado y hay muchas maneras en que las mujeres pueden ser ayudadas. La primera es buscar a un profesional calificado para que ayude a hacer el diagnóstico apropiado. Un profesional de primera línea en salud materno infantil; es decir, un trabajador social, psicólogo, obstetrica, enfermera o pediatra, debe ser la primera visita cuando una mujer y su familia piensan que algo está mal.

Una conversación honesta sobre emociones es esencial y generalmente se recomienda un examen físico. Frequentemente una consulta con un psiquiatra es necesaria para evaluar la necesidad de medicamentos. Muchas mujeres se recuperan rápidamente con el medicamento apropiado y están emergiendo nuevas investigaciones que puede contrastar las preocupaciones sobre usos medicamentos mientras las madres dan pecho.

Hay muchas cosas que las mujeres y sus familias pueden hacer para evitar sufrimiento emocional adicional.

* Cuidese lo más que pueda. Comer bien, dormir, y ejercicio suave no parece ser mucho, pero son restauradores físicos y emocionales.

* Diga “no” a tareas adicionales. Quizás normalmente invitan a la familia a comer todos los domingos, pero ahora puede ser el momento de darle la tarea a otro. Si no, comere comida preparada y use platos de papel.

* Converse. Hablele a su cónyuge, a sus amigos, a sus padres, a su médico. Estarás menos aislado y avergonzado cuando los pensamientos no están encerrados dentro de ti. Si lo que sientes y dices es preocupante, tu conversación te ayudará a obtener la ayuda que necesitas rápidamente.

* Pide ayuda —no solamente intervenciones de salud mental, sino ayuda para cuidar al bebé, limpiar la casa, más tiempo libre del trabajo, y ayuda con las compras en el supermercado. Todo esto puede aliviar la presión. Hay mucho trabajo para las madres de los recién nacidos y un poco descanso también puede darle el tiempo para descansar y renovar las energías.

Ha habido mucho más cobertura en la prensa sobre la depresión materna y post parto durante los últimos dos años de lo que hemos visto antes. Es importante que las mujeres, y las personas que comparten sus vidas, tengan conciencia de estos problemas y sepan como
intervenir y ayudar si hay un problema.

Muchas madres y padres han encontrado bondad y apoyo en sus familias, comunidades y amigos. Están agradecidos de tener a personas sobre quienes apoyarse y de poder tener ayuda para el cuidado de los niños y los difíciles horarios para el transporte de los niños.

Para la mayoría de las mujeres, la tristeza realmente pasa rápidamente, y es reemplazada con la felicidad normal y trabajo de ser nuevas madres.

Sandy Wolkoff, CSW, es la Directora de Marks Family Right from the Start 0-3+ Center. Es escritora independiente y especialista en párvulos por más de 25 años, la Sa. Wolkoff es una educadora y consultora reconocida a nivel nacional. Aparece frecuentemente en televisión y radio, y también es directora del programa de Depresión Materna en el North Shore Child & Family Guidance Center.

¿Estás experimentando depresión post parto?
Hay cuestionarios que han sido desarrollados por especialistas médicos y de salud mental que pueden ayudar a identificar a las personas que están sufriendo de depresión post parto y están lidiando con una crisis seria. Un profesional puede rápidamente evaluar si una mujer está experimentando síntomas preocupantes y necesita apoyo o intervenciones adicionales.

Algunos de estos problemas incluyen:
- Tengo problemas de insomnio, incluso cuando mi bebé duerme.
- Siento que mis emociones son muy inestables.
- Tenía miedo que nunca iba a ser normal otra vez.
- Sentía que no era la madre que quería ser.
- Me angustiaba por las cosas más sencillas que afectaban a mi bebé.

Las madres que están muy deprimidas se abrumarán por lo que están sintiendo, su propio sufrimiento, y sus temores de que le están causando sufrimiento a otros. Pueden pensar que no vale la pena vivir. Es importante recordar que la depresión post parto puede ser tratada. Por favor comunícate con su profesional local de salud o con un especialista en salud mental o con el Departamento de Salud Mental de su ciudad para ubicar servicios cerca suyo.

(Fuente: PISS, Cenl Tatuma Beet, Ph.D., and Robert K. Gable, Ed.D. copyright 2003, Western Psychological Services)

Translated by TIKAL Translations
(212) 569-6475
You are not alone.
You are not to blame.
You will feel better and be well with help.

The Postpartum Resource Center of New York
Perinatal Mood and Anxiety Disorders: Finding the help you need!

Helpline:
(Hablamos Español)
1-855-631-0001
or
631-422-2255
www.postpartumny.org
Before, during and after having a baby, parents may feel sad, fear, worry and alone.

**Pregnancy and Postpartum Depression / Anxiety**

**Signs may include:**

*Crying*

*Sleep problems*

*Trouble with eating*

*Anxiety/panic/scary thoughts*

*Anger/irritability*

*Loss of enjoyment*

*Fear of harming baby or yourself*

If you or someone you know are in need of help, the Postpartum Resource Center of New York provides:

*Helpline with *Moms on Call* and Family Telephone Support*

*Free and confidential information*

*Healthcare and support group resources*

*Perinatal Mood Disorders Prevention Program*

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**Helpline:**

(Hablamos Español)

1-855-631-0001

or

631-422-2255

www.postpartumny.org

As with any illness, please seek the advice of your healthcare provider.

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Usted no está sola. Usted no es culpable. Usted se puede mejorar y sentirse bien con ayuda.

El Centro de Recursos Postpartum de Nueva York
Perinatal y después del parto: encontrando la ayuda que usted necesita

Servicio de ayuda: (Hablamos español)
1-855-631-0001
o
631-422-2255
www.postpartumny.org
Antes, durante y después del nacimiento de su bebé, los padres pueden sentir tristeza, miedo, preocupación, y soledad.

Como con cualquier otra enfermedad, le aconsejamos que busque ayuda médica.

Las síntomas de depresión durante el embarazo y después de dar a luz incluyen:

*Llorar
*No dormir bien
*Disturbios en el apetito
*Ansiedad/pánico/pensamientos miedosos
*Enojo/irritación
*No gozar de las actividades
*Miedo de hacer daño al bebé o a sí misma

Si usted o alguien que usted conozca necesita ayuda, El Centro de Recursos Postpartum de Nueva York provee:

*Ayuda telefónica con otras madres para usted y toda la familia
*Información gratis y confidencial
*Grupos de apoyo durante el embarazo y después del parto
*Un programa de prevención para la depresión antes y después de dar a luz.

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