



# Perinatal Depressive and Anxiety Disorders

Statewide Obstetric Support Unit





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## INTRODUCTION

This Quick Reference Guide is designed to assist clinicians when managing women with perinatal mental health problems - primarily depressive and anxiety disorders.

Although common, mental health problems are often not identified in women at this important time in their lives.

Without treatment, mental health disorders may alter the mother's physiological and behavioural responses, which can seriously affect the wellbeing of the woman, fetus, child and family. Maternal suicide is a leading cause of maternal mortality in Australia.

It is therefore essential to effectively screen, diagnose, manage and refer women. Early intervention is recommended.

Complete Perinatal Depressive and Anxiety Disorders Guidelines and associated training seminars have been developed to improve the care of women with perinatal mental health problems.

For further information and references, see the companion document entitled:

“Perinatal Depressive and Anxiety Disorders: Clinical Guidelines for Western Australia” located under health professionals - manuals and directories page on KEMH's website: [www.wnhs.health.wa.gov.au](http://www.wnhs.health.wa.gov.au).

## DIAGNOSTIC CRITERIA

Depressive and anxiety disorders are common—occurring in about 1 out of 5 women within a year of childbirth—and they often occur together. Problems with thyroid function, anaemia, sleep deprivation, or bereavement can contribute to the symptoms and should therefore be excluded and treated separately. Age, culture and other contextual factors (history of abuse or loss) can impact diagnosis.

### Depressive Disorders

The possibility of an underlying Bipolar Mood Disorder should be borne in mind when there is a family history of bipolar disorder or if the depressive disorder is melancholic or treatment-resistant.

Some women can suffer extreme exhaustion or depression. They may not warrant a diagnosis of depression, but require assistance nonetheless to prevent a more serious mood disorder.

#### Major Depressive Disorder

Symptoms include:

- depressed mood
- Anhedonia (no interest or pleasure)
- unexpected change in weight or appetite
- markedly increased or decreased sleep, can't return to sleep after care for baby
- fatigue or loss of energy
- feelings of worthlessness or guilt
- reduced concentration
- recurrent thoughts of death or suicide
- psychomotor agitation or retardation.

#### Minor Depressive Disorder

Same symptoms generally as above, but of shorter duration and/or fewer symptoms reported than for Major Depressive Disorder.

#### Dysthymic Disorder

Some women report chronic low-grade depressive symptoms that can persist for years and go unrecognised unless specific inquiry is made. This disorder may substantively interfere in bonding and attachment.

## Postpartum / Maternity / “Baby Blues”

Symptoms include:

- labile mood, tearfulness, irritability
- sleep problems
- anxiety.

Baby blues affect 30-85% of new mothers, peak about days three to five after birth then resolve quickly. If symptoms are severe or persistent, consider a diagnosis of depressive disorder.

## Puerperal or Postpartum Psychosis

Symptoms include:

- sleeplessness, hyperactivity or stupor
- hallucinations
- delusional beliefs
- rapid mood swings
- disorientation and confusion
- reduced ability to think clearly
- lack of appetite
- intermittent lucid periods.

Puerperal psychosis affects less than 1% of mothers and is usually related to underlying bipolar disorder or occasionally schizophrenia or schizoaffective disorder.

## Bipolar Disorder

- Bipolar I - presents as mania with psychotic features that is often followed by major depression.
- Bipolar II - presents as depressive episodes or dysthymia<sup>1</sup> and brief episodes of hypomania.

Common comorbid conditions to investigate include substance abuse and suicidality.

Relapse during and after pregnancy is very common in women with a history of bipolar disorder.

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<sup>1</sup> If duration is less than six months, a diagnosis of Adjustment Disorder might be more appropriate

## Anxiety Disorders

Frequent visits to the GP or obstetrician can signal underlying anxiety and/or depressive disorder.

### Generalized Anxiety Disorder

Generalized Anxiety Disorder appears more commonly in postnatal women than in the general population. It features persistent and excessive anxiety and worry of six months duration or more<sup>2</sup>. The anxiety or worry is about a number of events or activities, the woman cannot easily control the worry, and it interferes with daily functioning.

Symptoms include:

- restlessness, feeling on edge
- easily fatigued
- difficulty concentrating
- irritability
- tense muscles
- disturbed sleep.

### Fears and phobias

Pointers to a diagnosis of a significant fear or phobia of childbirth include avoidance or termination(s) of pregnancy, or request for birth by Caesarean section. Severe fear of childbirth is a risk factor for developing Post traumatic Stress Disorder.

Inability to sleep after the birth might signify fear that the baby will die from cot death.

### Panic Disorder

Symptoms include:

- heart palpitations, sweating, trembling
- shortness of breath, chest discomfort, upset stomach
- fears of losing control, going crazy or dying
- feeling dizzy, unreal or detached
- paraesthesias and hot or cold flushes.

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<sup>2</sup> If duration is less than six months, a diagnosis of Adjustment Disorder might be more appropriate



## Obsessive-Compulsive Disorder (OCD)

- Obsessions are “recurrent, unwelcome thoughts, ideas, or doubts that seem senseless, yet give rise to anxiety/distress”
- Compulsions are “urges to perform excessive behavioural or mental acts to suppress or neutralise the obsessional distress”.

Obsessional thoughts commonly involve imminent disaster and harm to the baby such as thoughts of infanticide or child sexual abuse. Common compulsions include cleaning the hands and house.

Checking behaviour commonly relates to the newborn’s well being, such as repeatedly checking on the baby during the night.

## Posttraumatic Stress Disorder (PTSD)

Symptoms include:

- intrusive symptoms such as nightmares and flashbacks
- heightened arousal like anxiety or exaggerated startle reflex
- avoidance of reminders of the traumatic event(s) such as medical institutions and staff, or the baby’s cry; avoidance of sexual intimacy.

A common co-morbid condition is depression. Approximately 2% to 3% of women suffer from PTSD after childbirth. During labour these women experienced extreme pain, loss of control and a fear of death of themselves or their infant.

Typically these women are reluctant or embarrassed to seek help and may discharge themselves early from hospital to avoid reminders of the birth.

Symptoms might increase during a subsequent pregnancy as evidenced by unexplained desire for termination or Caesarean Section under general anaesthesia.

## Adjustment Disorders

- These are clinically significant emotional or behavioural changes in response to an identifiable stressor.
- Symptoms are of depression and/or anxiety.

Adjustment disorders are transient. They begin within three months of a stressor and end within six months. If the duration is longer it is considered chronic.

# SCREENING

## When to Screen for Depression and Anxiety

Screen women for diagnostic symptoms of anxiety and depression at:

- booking visit
- third trimester visit
- postnatal check(s).

## Methods of Screening

### Brief verbal screen

A brief verbal screening interview should at a minimum cover:

- mood and anxiety over the past two weeks
- personal and family history of mental health problems
- thoughts of harm to self or baby
- level of pleasure and interest in normally enjoyable activities
- feelings of uselessness or guilt.

### Risk factors review

Risk for relapse of mental health disorders is high during and after pregnancy, especially for bipolar disorder. Screening based on a review of risk factors can be incorporated into routine history taking by noting the following factors associated with perinatal mental health problems:

### Psychological

- Antenatal anxiety, depression or mood swings
- Previous history of anxiety, depression, or mood swings, especially if occurred perinatally
- Family history of anxiety, depression or alcohol abuse, especially in first degree relatives
- Severe baby blues
- Personal characteristics like guilt-prone, perfectionists, feeling unable to achieve, low self-esteem
- Edinburgh Postnatal Depression Scale Score (EPDS) greater than or equal to 12

## Social

- Lack of emotional and practical support from partner and/or others
- Domestic violence, history of trauma or abuse (including childhood sexual assault)
- Many stressful life events recently
- Low socioeconomic status, unemployment
- Unplanned or unwanted pregnancy
- Expecting first child or has many children already
- Child care stress

## Biological / medical

- Ceased psychotropic medications recently
- Serious pregnancy or birth complications, neonatal loss, poor physical health, chronic pain or disability, or premenstrual syndrome
- Significant perinatal sleep deprivation
- Neonatal medical problems or difficult infant temperament

## Mental status examination

A more formal approach to screening and diagnosing mental health problems is to conduct the mental status examination that includes assessment of:

- appearance, behavioural observations
- conversation, speech
- mood - in the past two weeks
- personal and family history of mental health problems
- self-harm / suicidal thoughts or actions, thoughts of death or dying
- harm to baby - thoughts, actions, harm to others in the past or future
- sleep - initial / middle / terminal insomnia, how long to fall asleep after attending to the baby / toilet
- level of pleasure and interest in normally enjoyable activities.
- feelings of uselessness or guilt
- appetite, motivation, energy
- anxiety, worries, phobias
- obsessions, compulsions
- thought processes and content, attention/concentration, orientation, memory and unusual perceptual experiences.

## Edinburgh Postnatal Depression Scale

The Edinburgh Postnatal Depression Scale (EPDS) should be offered at least once antenatally and postnatally. As it highlights risk rather than diagnosis, further assessment must be conducted for those who give a positive response to item 10 (self-harm) or for those whose score is 12 or more.

## Screen for childbirth trauma

Ask all postnatal women how the birth experience was to uncover diagnostic symptoms of trauma. Ask about:

- the overall experience
- levels of pain
- satisfaction of care provided.

## Suicide Risk Assessment

Ask about:

- suicidal thoughts
- plans
- attempts
- control over suicidal thoughts

If concerns are raised, note further:

- access to means of suicide (tablets, firearms)
- family history of suicide
- persistent thoughts of death or dying
- hopelessness, anhedonia
- psychiatric disorder like depression or psychosis; personality disorder
- substance abuse, greater risk if also depressed
- social isolation, withdrawal, limited communication
- single marital status, divorce, separation, relationship break-up
- recent loss, or death in family / close associate
- chronic insomnia and/or other health problems such as pain or disability.

Multiple risk factors increase the overall risks generally. Suicidality compels consultation and a decision whether to refer to a mental health clinician. Continue to monitor closely even after psychiatric hospitalisation.

No evidence supports the clinical practice of asking the patient to provide a “contract for safety”.

## Risk of Harm to Baby

Enquire about:

- thoughts of harm to baby
- actions (such as shaking)
- strategies used to cope with frustration
- substance misuse
- social supports
- her confidence that she can keep the baby safe.

## MANAGEMENT

Some of the negative effects of depressive and anxiety disorders can be reduced through effective pharmacological and psychosocial interventions. The published research evidence for antenatal treatment efficacy is weak in contrast to the evidence for treatment of postnatal women or women not in the perinatal time-frame. Nonetheless, early intervention is recommended.

## Medications in Pregnancy and Lactation

### Risks and benefits analysis

Discuss with the woman and her partner the relative risks and benefits to the mother and fetus/baby of different treatment options.

- Conduct a full analysis of exposure to other medications and substances with an aim to reduce non-essential exposures
- Examine the impact of untreated illness on the fetus/baby
- Seek a treatment with appropriately speedy response (eg. for moderate to severe depression, medication might be a better choice than psychotherapy since the latter takes more time to yield satisfactory treatment effects)
- Consider psychotherapy
- When prescribing medication, try to select one that has been previously effective for the woman

## General prescribing issues

- Generally, ***the more severe or refractory forms of mental illness are more likely to require medications while women with less troubling symptoms may opt for other treatments.*** It has been recommended that antidepressant medication be seriously considered for women with moderate to severe depression. Those women who wish to discontinue medication during pregnancy will require close monitoring (for recurrence of symptoms) and psychological treatment.
- If symptoms of psychosis are present with depression, antidepressants must be prescribed with caution as these medications can precipitate rapid mood cycling if the underlying diagnosis is bipolar disorder.
- The ***lowest effective dosage*** is recommended with frequent monitoring of its efficacy in maintaining euthymia. Keep in mind that physiological changes during pregnancy can result in lower plasma concentrations of medications.
- ***Fewer agents*** are recommended: some agents have more than one effect (eg. antidepressant and sedation).
- ***Selective serotonin reuptake inhibitors (SSRIs) and serotonin and noradrenaline reuptake inhibitors (SNRIs)*** are considered to be appropriate choices to treat ***depression***. Avoid paroxetine in the first trimester.
- Toxicity should be a consideration if the woman is ***suicidal***: ***SSRIs are less toxic in overdose*** than tricyclic antidepressants (TCAs) and monoamine oxidase inhibitors (MAOIs). The side effect spectrum is generally more tolerable for the SSRIs.
- ***Benzodiazepines*** used during the first trimester of pregnancy have been associated with a very slight increase in incidence of oral cleft and major malformations in some, but not all studies. They are considered safe after 12 weeks gestation. Some authors have argued for selection of short-acting drugs if this class of medications is used. Benzodiazepines can lead to more substantial withdrawal symptoms in the baby than those from SSRIs, and may include: hypertonia, hyperreflexia, excessive crying, tremors, bradycardia, restlessness, irritability, seizures, abnormal sleep patterns and cyanosis.
- A decision based on the individual is advised when considering whether to ***taper the psychotropic medication*** dosage a few

weeks before birth. This may be a time of heightened anxiety when continued medication use or the use of anxiolytic medications can be helpful (eg. in controlling agitation).

- In the case of **antidepressants** (tricyclics, SSRIs and SNRIs), tapering of dosage might not be necessary. The baby should be observed in hospital for more than 48 hours after birth in case of discontinuation<sup>3</sup> symptoms. These symptoms may be jitteriness, self-limiting respiratory difficulties, tachypnoea, problems with feeding, hypotonia/hypertonia, hypothermia and seizures. Short-acting SSRIs (like paroxetine: which is contraindicated in the first trimester) are more likely to cause these symptoms than long-acting ones such as fluoxetine.
- If milk supply decreases with antidepressant use, increase fluid intake and frequency of feeding.

Useful sources of up-to-date prescribing information are included in the section ‘More Information Can be Found to Follow’ and the ‘Reference List’ (on-line).

Contact the Mother and Baby Unit at KEMH for further information on (08) 9340 1799.

## Other Biological / Physiological Treatments

### Electroconvulsive Therapy (ECT)

For severe cases of psychiatric illness, ECT has been demonstrated to be a safe option during pregnancy with appropriate multidisciplinary medical involvement.

### Biologically based treatments

For women who do not benefit from medications or who prefer more “natural” approaches, other biologically based treatments have been trialled with varying levels of success eg. hormonal interventions, St Johns Wort, omega-3 or fish oil. Further research is needed in all of these areas before recommendations can be given.

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<sup>3</sup> Shelton (2006) describes SRI discontinuation syndrome as distinct from withdrawal: the latter is associated with craving and drug-seeking behaviour whilst discontinuation is associated with a time-limited re-emergence of anxiety and depressive symptoms, flu-like symptoms and paresthesias. The discontinuation syndrome is easily managed, again differentiating it from withdrawal.

## Psychosocial and Other Forms of Management

Psychological treatments have at least short-term efficacy in the treatment of Postnatal Depression (PND), comparable to medications in mild to moderate depression.

### Cognitive Behavioural Therapy

Cognitive Behavioural Therapy is based on a set of fundamental premises:

- cognitions affect behaviour
- cognitions can be attended to and changed
- changes in cognitions can effect changes in behaviour.

Treatment may target coping skills, problem-solving activities and/or dysfunctional thoughts in efforts to bring about improved functioning. This is typically within a set number of sessions in individual or group sessions. Its effects are well demonstrated and durable for anxiety and depressive disorders.

### Interpersonal Psychotherapy

Interpersonal psychotherapy is a time-limited form of psychological therapy, which focuses on interpersonal functioning as a means to improve mood and interpersonal distress. Goals of the therapy might include:

- improving or changing a woman's expectations about interpersonal relationships
- building and using effective support networks
- improving interpersonal communication with a more flexible style of attachment.

Interpersonal psychotherapy is an effective individual treatment for perinatal mood disorders and is used in group-based interventions as well.

### Non-directive counselling

Non-directive counselling is a broad term encompassing good listening skills and avoidance of advice-giving with the premise that women can solve their problems through reflection and talking through issues.

### Voluntary support

The PND Support Association (PNDSA) provides telephone and group support to the women of Western Australia. They also develop brochures and engage in community events that highlight their services.



## Debriefing or “birth review”

Women should be offered the opportunity to talk about negative birth experiences in a “birth review”, but should not be pushed to do so.

## Groups: Therapy and peer support

Mood and anxiety disorders may be treated successfully by group therapy using Cognitive Behavioural Therapy (CBT) and Interpersonal Psychotherapy (IPT). Benefits of group therapy include:

- the provision of peer support with a wide range of exposure to other people’s problems and solutions
- the opportunity to socialise.

**Typical groups for women** are community based. Some are therapeutically oriented whilst others are primarily psycho-educational. Many include the father for one session to promote better understanding and to help generalise communication skills to the couple relationship.

**Groups for fathers** support men in their adjustments to fatherhood. Men have reported that group attendance helped them to understand and support their partners, and reduced their own stress levels.

## Couples and/or family counselling

As poor social support is a key risk for developing perinatal depressive and anxiety disorders, improving social relationships through counselling involving the partner or family is often recommended.

## Grief counselling

Grief counselling can be helpful immediately after a pregnancy loss and during a subsequent pregnancy.

## Mother and Baby Unit

Mother and baby units are psychiatric hospital facilities designed specifically for admission of mothers and their babies in a small, home-like unit. Typical treatments include biological, psychological, mothercrafting, parenting education and support, couple therapy and supportive counselling.

## Community Child Health Nurses and Child Development Services

Community child health nurses can assess children’s health and development, as well as, provide information about many aspects of parenting, maternal and family health and healthy lifestyles. There are 310 Child Health Centres across Western Australia.

In Perth and larger country areas, Child Development Centre health professionals, such as clinical psychologists and social workers, provide specialist support and counselling for women who have perinatal depressive and anxiety disorders. They also focus on enhancing the quality of parent-child interaction to support normal child development and secure attachment.

The community child health nurse will facilitate parenting groups for first-time mothers. Other parenting groups support stress and depression of women in the postpartum period, in conjunction with Child Development Centre health professionals.

Community child health nurses offer the EPDS to all mothers with new babies at 6-8 weeks, 3-4 months and 8 months postpartum. Fathers are also offered the EPDS if required. Depending on the results of the EPDS and their assessment, the nurse will:

- provide relevant information about services and routine care, including parenting and support groups for parents with no mental health issues
- monitor the mother's mental health status using strategies such as 'listening visits'
- make referrals to the GP and other services such as PND support groups and the 'Best Beginnings' intensive home-visiting program
- refer for specialist perinatal mental health assessment
- make direct referrals for emergency mental health treatment.

### **Parenting Services**

Centres such as Ngala, Meerilinga and women's health care houses offer a wide range of parenting supports, including assistance with feeding and sleeping problems. Group-based parenting programs may improve the psychosocial health of mothers. Preparation for parenting might be useful in the short-term for women with low self-esteem.

Treatment of an unsettled infant is often the entry into assessment and treatment of a maternal mood disorder since infant problems and maternal mood disorder often occur together.

## REFERRAL

For those women with a high score on the **EPDS ( $\geq 12$ )** and/or other significant risk factors, further assessment is recommended to confirm a diagnosis and arrange treatment.

Clinicians with special skills in mental health assessment include mental health nurses, psychologists, general practitioners and psychiatrists. The process of referral to a mental health specialist demands good communication to promote patient attendance and cooperation. A clear explanation of the purpose and benefits to the woman and her family are critically important, with reassurance where necessary.

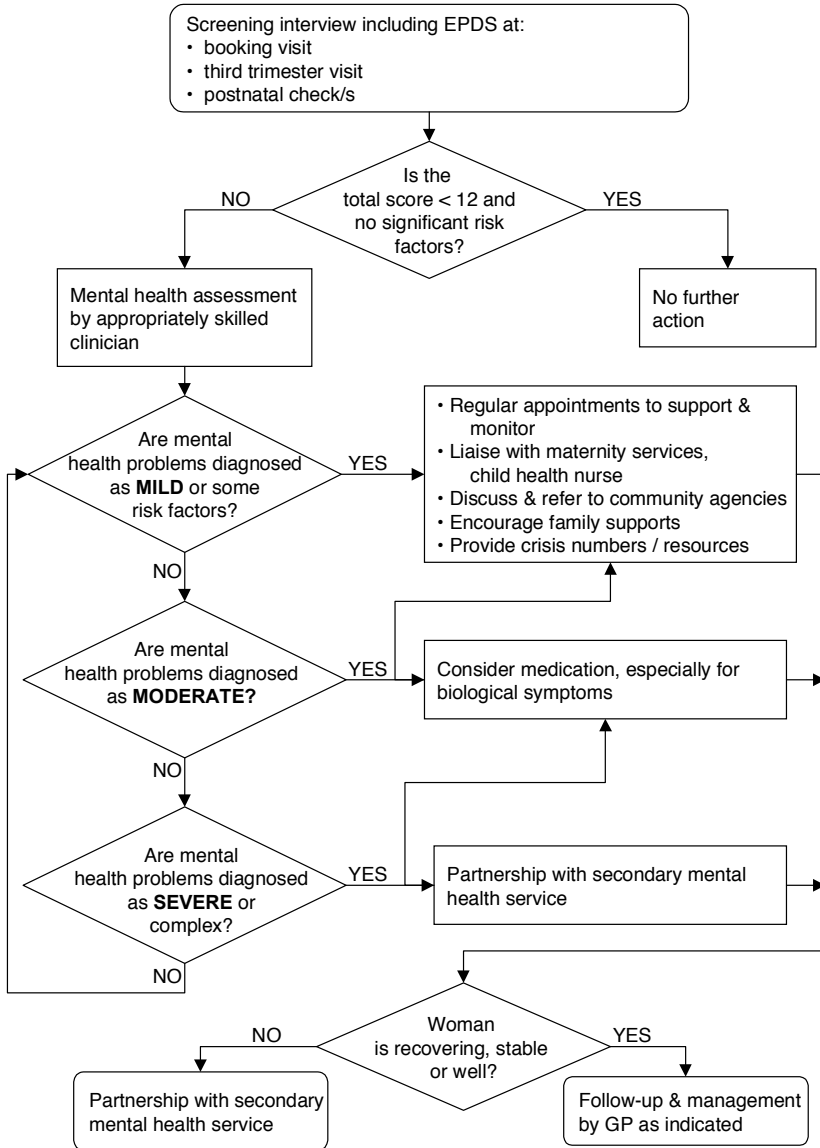
Referral to a psychiatrist should be considered if the woman has:

- Bipolar Disorder
- severe or psychotic depression
- active suicidal thoughts
- no response to treatment.

When in doubt, discuss with a mental health specialist.

**Psychosis constitutes a psychiatric emergency necessitating urgent referral.**

# CARE PATHWAY



## MORE INFORMATION CAN BE FOUND

### Websites

[www.nps.org.au](http://www.nps.org.au) The National Prescribing Service has newsletters and links regarding diagnosis, prescribing medication and special topics

[www.tg.com.au](http://www.tg.com.au) TGA: Therapeutic Guidelines Limited (2006)

[www.beyondblue.org.au](http://www.beyondblue.org.au) The national depression initiative *beyondblue* website has a section devoted to perinatal issues

[www.yourzone.com.au/perinatalhealth](http://www.yourzone.com.au/perinatalhealth) designed for consumers, but can assist professionals to identify local resources

[www.community.wa.gov.au/onlineresourceguide/](http://www.community.wa.gov.au/onlineresourceguide/) Domestic Violence online resources

[www.community.wa.gov.au/Resources/Child+Protection/](http://www.community.wa.gov.au/Resources/Child+Protection/) Child Protection resources

[www.community.wa.gov.au/Publications/FactSheetsAndGuides/Courses\\_Guide.htm](http://www.community.wa.gov.au/Publications/FactSheetsAndGuides/Courses_Guide.htm)

Community-based courses on parenting, PND and other topics, sponsored by DCD

[www.health.wa.gov.au/services/category.cfm?Topic\\_ID=18](http://www.health.wa.gov.au/services/category.cfm?Topic_ID=18) or

<http://intranet.health.wa.gov.au/royalstreet/content/directorate.cfm?divID=93&dirID=99>

State Child Health Nurse locations and timetable

[www.relationshipsaustralia.org.au](http://www.relationshipsaustralia.org.au) Relationship counselling

[www.mhcs.health.nsw.gov.au/mhcs/topics/Pregnancy\\_and\\_Post\\_Natal.html](http://www.mhcs.health.nsw.gov.au/mhcs/topics/Pregnancy_and_Post_Natal.html) A range of topics including EPDS in English and other languages

[www.sign.ac.uk](http://www.sign.ac.uk) Scottish guidelines #60 refer to Puerperal Depression and Psychosis

[www.psychology.org.au/psych/referral\\_service](http://www.psychology.org.au/psych/referral_service) to locate a clinical psychologist registered with Medicare.

## Contact Numbers

Commonwealth Carelink Centre	1800 052 222	Provides information about community support services for mental health clients.
KEMH Department of Psychological Medicine - duty officer	(08) 9340 1521	Perinatal and postnatal mental health services for KEMH patients & duty calls
KEMH Pharmacy	(08) 9340 2723	Obstetric Drug Information Line
Mental Health Emergency Response Line  Previously known as Psychiatric Emergency Team	East Perth: 1300 555 788  Rural FREECALL: 1800 676 822 TTY: 1800 720 101	
Mental Health Services		See <a href="http://www.whitepages.com.au">www.whitepages.com.au</a> and search for “mental health services” for complete listing
Mother Baby Unit - KEMH	(08) 9340 1799	
Ngala	(08) 9368 9368 / 1800 111 546	<a href="http://www.ngala.com.au">www.ngala.com.au</a>
PNDSA	(08) 9340 1622	Volunteer support association
Pregnancy Loss Service at KEMH	(08) 9340 2128	
SJOG Raphael Centre	(08) 9382 6828	Perinatal and postnatal mental health services

## EDINBURGH POSTNATAL DEPRESSION SCALE (EPDS)

The EPDS was originally developed for screening after birth but is now used antenatally as well. It is available in many translated versions. Items 3, 4 and 5 may pick up symptoms of anxiety.

Responses are scored 0, 1, 2, or 3 according to increased severity of the symptom. Items marked with an asterisk (\*) are reverse scored (ie. 3, 2, 1, and 0). The total score is determined by adding together the scores for each of the 10 items.

The EPDS is only a screening tool. It does not diagnose depression - that is done by appropriate health care personnel. Users may reproduce the scale without permission providing the copyright is respected by quoting the names of the authors, title and the source of the paper in all reproduced copies.

### Instructions for Users

1. The mother is asked to underline the response which comes the closest to how she has been feeling the previous 7 days.
2. All ten items must be completed.
3. Care should be taken to avoid the possibility of the mother discussing her answers with others.
4. The mother should complete the scale herself, unless she has limited English or has difficulty with reading.

36 translated copies of the EPDS are available. For a copy telephone (08) 9340 1795 and request the resource titled - *Using the Edinburgh Postnatal Depression Scale (EPDS)*: translated in languages other than English: State Perinatal Mental Health Reference Group; 2006. Produced by the Department of Health, Government of Western Australia.

## Edinburgh Postnatal Depression Scale (EPDS)

As you are pregnant or recently had a baby, we would like to know how you are feeling. Please UNDERLINE the answer which 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  
   No, not very often  
   No, not at all

This would mean: “I have felt happy most of the time” during the past week. Please complete the other questions in the same way.

IN THE PAST 7 DAYS
<p><b>1. I have been able to laugh and see the funny side of things</b> As much as I could Not quite so much now Definitely not so much now Not at all</p>
<p><b>2. I have looked forward with enjoyment to things</b> As much as I always did Rather less than I used to Definitely less than I used to Hardly at all</p>
<p><b>*3. I have blamed myself unnecessarily when things go wrong</b> Yes, most of the time Yes, some of the time Not very often No never</p>
<p><b>4. I have been anxious or worried for no good reason</b> No, not at all Hardly ever Yes, sometimes Yes, very often</p>



**\*5. I have felt scared or panicky for no 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 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, not at all

**\*10. The thought of harming myself has occurred to me**

- Yes, quite often
- Sometimes
- Hardly ever
- Never

Cox JL, Holden J, Sagovsky R. Detection of postnatal depression. British Journal of Psychiatry. 150:782-6;. 1987.



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Delivering a Healthy WA

Healthy Workforce • Healthy Hospitals • Healthy Partnerships  
Healthy Communities • Healthy Resources • Healthy Leadership