EVALUATING PERINATAL MOOD DISORDERS
For Healthcare Providers
• Nothing to disclose
Educational Objectives

- Understand Perinatal Mood Disorders
- Describe appropriate screening procedures for perinatal mood disorders
- Develop a plan for identifying women at risk and those already suffering from PMDs
- Develop a plan of care for at risk women and women suffering from PMDs
- Develop a chain of communication for caregivers so that treatment and support can be provided promptly
- Assure each woman receives appropriate ongoing care and follow-up
Staff Expectations

• Staff should be familiar with the screening tools used in the office and able to implement them with comfort
• Staff should have up-to-date contact information for local emergency services
• Patients should have direct access to a provider in case of an emergency
• Community resource contacts should be readily available
Incidence of PMADs

• Occurs in 10-20% of postpartum women and as many as 1 in 4 in Oregon

• 800,000 women a year in the U.S.

• 1/3 of PMADs begin DURING pregnancy
Common Comorbid Disorders

• Alcohol abuse
• Substance abuse
• Smoking
• Eating Disorders
• Personality Disorders
Perinatal Mood and Anxiety Disorders

• Baby Blues: not a disorder
• Depression
• Anxiety
• Panic Disorder
• Posttraumatic Stress Disorder (PTSD)
• Obsessive-Compulsive Disorder (OCD)
• Psychosis
• Bipolar Disorder
BABY BLUES
Not a true disorder
Occurs in 80% of population
What is Baby Blues?

• Part of the normal Adjustment to motherhood

• Not associated with traumatic birth

• Occurs early: day 3-5 postpartum

• Tearfulness alternated with feeling “normal”

• Usually resolves by two weeks postpartum
PREGNANCY RELATED ANXIETY/DEPRESSION
Risk factors for Depression/Anxiety

- Prior depression/anxiety
- Unplanned pregnancy
- Domestic violence
- Substance abuse
- Discord with partner
- Medical complications

- Prior perinatal loss
- Complications with fetus
- Social isolation
- Poor social support
- Discontinuing antidepressant (50-75% relapse rate)
Occurs in 10-20% of women
This is the MOST COMMON postpartum complication!!!!!

POSTPARTUM DEPRESSION/ANXIETY
Symptoms of Postpartum Depression

- Depressed mood
- Lack of energy
- Poor appetite
- Sleep disturbance
- Worthlessness and guilt
- Difficulty concentrating
- Disinterest in baby or difficulty bonding
- Hopelessness
- Excessive concern for baby
- Suicidal thoughts
- Agitation, racing thoughts, inability to sit still
- Anger or irritability
Impact of Untreated PPD

- May effect cognitive develop of newborn and young child
- May lead to behavioral issues in young child
- Neurologic delay in infants of depressed mothers
- Poor weight gain in infants of depressed mothers
- Suicide accounts for up to 20% of postpartum deaths
POSTPARTUM PANIC DISORDER
Symptoms of Postpartum Panic Disorder

- Panic Attacks or episodes of extreme anxiety
- Shortness of breath or sensation of smothering
- Shakiness
- Numbness or tingling
- Heart racing
- Nausea/vomiting
- Restlessness, agitation
- Feeling of impending doom
Occurs in 1-6% of postpartum women

POSTPARTUM PTSD
Postpartum PTSD- Causes

- Prior traumatic event

- Traumatic labor/delivery- “in the eye of the beholder”

Neonatal complications
Symptoms of Postpartum PTSD

- Intrusive re-experiencing of traumatic event via visions, flashbacks, nightmares
- Hyper arousal or hyper vigilance
- “Emotional numbing”
- Avoidance of reminders of childbirth
- Isolation
- Lack of concentration
- Anger
- Irritability and mood swings
Obsessions occur in 3-5% of postpartum mothers

POSTPARTUM OBSESSIVE-COMPULSIVE DISORDER (OCD)
Postpartum OCD Symptoms

- Obsessive thoughts
  - Content related to baby
  - Mother extremely distraught
  - “Am I going crazy?”
  - Fear of PP Psychosis

Compulsive Behaviors
- Keeping baby safe
- Reduce distress
- Gain order and control
Postpartum OCD Characteristics

- No intent to act on “scary thoughts”
- Mother rarely discloses thoughts or obsessions
- Functioning and infant care may be compromised
- Lifelong mild symptoms
- Obsession with safety to avoid harm
- Frequent office visits for reassurance
Occurs in 1-2/1000 women

5% risk of suicide and 4% risk of infanticide

POSTPARTUM PSYCHOSIS
Risk Factors for Postpartum Psychosis

- Psychotic Disorders (20-50%)
- Bipolar Disorders (20-50%)
- Previous Postpartum Psychosis (50-70%)

- WARNING SIGN: EXTREME SLEEP LOSS
Symptoms of Postpartum Psychosis

• Usually begins about 3 days postpartum but can begin almost immediately after delivery, rarely occurs after 4 weeks PP
• Often visual or auditory hallucinations
• Confusion, paranoia and extreme mood swings
• Delusional thinking
• Symptoms may wax and wane
Treatment for Postpartum Psychosis

• TRUE PSYCHIATRIC EMERGENCY
• Requires inpatient hospitalization
• Treatment with antipsychotics
• Psychotherapy
• ECT
Office staff are key in arranging and advocating for mental health services for women with PMDs.
What Office Staff Can Do:

- Contact insurance company with relevant information to set up mental health care
- Contact mental health providers with specialty in PMDs and arrange appointments for patients in an expedited fashion
- Assure directions and transportation are provided to the patient
- Assure appropriate practitioner follow up is arranged
- Provide frequent follow up phone contact
- Arrange social support for the patient as appropriate
CARE PATHWAY FOR HEALTHCARE WORKERS

The cookbook for treating women with PMDs
Who Gets Screened?

• ACOG and AAP recommend screening but with no specific guidelines.
• Evidence is based on risk assessment and quality of available interventions.
• We recommend:
  • Screening in the first trimester (or first prenatal visit)
  • Screening in the third trimester – symptoms often worsen at this time
  • Screening at 2 and 6 weeks postpartum
  • Screening at 3-4 months postpartum or with cessation of breastfeeding
Assess, Assess, Assess

- Front office, back office, nursing and physicians/midwives
- Initial assessment should include open-ended, non-judgmental questions
- Questions include ability to sleep, eat, feelings both positive and negative, concerns, scary thoughts.
- Appearance, facial expressions, affect, “the mask”
- Missed appointments, late arrival
- See list of possible assessment questions....
Basic Screening Questions for Healthcare Providers

- Are you able to sleep at night if everyone else is asleep?
- How is your appetite? Do you feel you are getting enough to eat?
- Are you having any unusual or scary thoughts?
- Do you generally “feel like yourself?”
- Many women feel ex: nervous, jumpy, irritable, sad? Do you ever feel this way?
How Do I Give the EPDS?

- “Because you are pregnant or just had a new baby we would like to know how you are feeling. Please mark the answer that comes closest to the way you have felt over the past several days.”
- Remind moms to be open and honest
- Remind them there is no “right answer.”
- Remind them it is OK to be unhappy.
What Do I Do With The Score?

- Four or Less: not currently depressed, rescreen at next visit

- 5-9: Increased risk for depression. Educate regarding signs and symptoms, give blank EPDS and WellMama brochure. If they self-score >9 they require an office visit.

- 10 or More: It is very likely your patient is depressed. Discuss treatment options, refer to mental health provider and supply hotline information. Make follow up appointment at a short interval!!
QUESTION #10

• Any answer to Question 10 other than NEVER requires immediate evaluation!!!
• Ask your patient about her suicidal thoughts.
• Ask her about a plan
• Determine whether she has weapons in her house
• Patients with suicidal thoughts need immediate mental health evaluation and should not be left alone!!
STRATEGIES FOR POSTPARTUM SUPPORT
Practical Help

• Mobilize and expand social support network - WellMama

• Professional help in the home through postpartum doulas and home health workers

• Healthy Start home visitation program

• Support groups

• Professional resources
Household Help

- Engage partner and family members
- Reprioritize housework
- Respite from baby care (Relief Nursery)
- Avoid negative feedback
Self-Care

- Adjust priorities (healthy mom=healthy baby)
- Lower expectations
- Hydration and Nutrition
- Improve sleep
- Light exercise
- Sunlight
Alternative Therapies

• Light Therapy
• Acupuncture
• Omega 3 supplements
• Massage
• Meditation
• Chinese herbal medicines
Counseling Services

- Importance of counselor experienced with PPMDs
- Cognitive Behavioral Therapy and Interpersonal Therapy best
Medication Management

- Many medications are safe with breastfeeding
- Risks and benefits must be weighed
- Patient must understand medications are not “forever” and frequent reevaluation is necessary
- SSRIs well studied
- Close follow up once medication is started is imperative!
SSRI use Postpartum

- The amount of medication exposure through breast milk is substantially less than in utero
- A 2004 meta-analysis by Weissman et al. looked at levels of 15 different antidepressants in breast milk.
  - Fluoxetine produced the highest drug levels in infants
  - Citalopram levels were also relatively high
  - Paroxetine levels were very low, even zero in many infants
  - Sertraline levels were also quite low.
  - Authors found paroxetine, sertraline and nortryptaline to have almost undetectable levels
- Signs of elevated drug levels in infants include irritability, poor feeding or uneasy sleep.