INDIANA PERINATAL NETWORK
www.indianaperinatal.org

INDIANA PERINATAL MOOD DISORDERS GUIDE

Symptoms, Treatment, Screening Tools & Resources

April 2005

This Guide is intended as a resource for clinicians involved in the care of the Obstetrical client. This information should not be interpreted as excluding other acceptable courses of care based upon medical judgement and patient preferences. The Guide reflects the current opinion of IPN for a standard approach to postpartum mood disorders.

SIGNS & SYMPTOMS

POSTPARTUM DEPRESSION

- ☐ **Symptoms** are insidious and can occur anytime up to a year after birth, usually within the first three months; a period of at least two weeks of depressed mood or loss of interest in almost all activities and at least four other symptoms from the following list:
  - Changes in appetite or weight, sleep and psychomotor activity
  - Decreased energy
  - Feeling of worthlessness or guilt
  - Difficulty thinking, concentrating or making decisions
  - Recurrent thoughts of death or suicidal ideation, plans or attempts
- ☐ May have an effect for up to a year or longer
- ☐ **Psychosocial predictors:**
  - Previous episodes of depression/mood disorders
  - Significant loss or life stress in the last year
  - An unplanned/unwanted pregnancy
  - Marital conflict
  - Low social support
  - Genetic predisposition
  - Fatigue
  - An infant with health problems
- ☐ **Biological risk factors:**
  - Decline in gonadal steroid hormones
  - Genetic factors
  - Reduced anti-inflammatory capacity
  - Elevated neurotransmitter systems
  - Lowered serum cholesterol
- ☐ Depressed mothers can physically appear to have no symptoms of depression; however, their parenting style, affect and interactions with the baby can reveal the emotional struggles the mother may be having and should be **assessed for these signs and symptoms:**
  - Negative emotional expressions
  - Insensitive and unresponsive parenting style
  - Mothers who feel disconnected from their infant
  - Feeling they are a "bad" or inadequate mother
  - Thoughts of harming their infant
- ☐ **Infants may appear**
  - Passive or avoidant (little eye contact with their mother or caregiver) which mirrors the mother's negative mood at home
  - Feeding difficulties, frequent illness, and babies who display passive or avoidant behaviors
- ☐ **PPD** can cause a strained relationship between the couple, impaired patterns of relating/communicating between the woman and her family, and negative cognitive & social development of children

POSTPARTUM OBSESSIVE/COMPULSIVE DISORDER

- ☐ Symptoms include:
  - Repetitive, intrusive thoughts of harming the baby (mother knows thoughts are irrational which causes her intense anxiety)
  - Fear of being left alone with the infant
  - Hypervigilance in protecting the infant
  - Most common form is fear of contamination, expressed by frequent hand-washing, obsessive neatness and organizing, hair-pulling (trichotillomania) or skin-picking.
- ☐ Prevalence rates not reported
- ☐ Appears to be a recurrent condition; subsequent pregnancies should be treated quickly after delivery
- ☐ Postpartum can be a time of worsening of OCD, with the added experience of depression
- ☐ Not at risk to actually harm baby

POSTPARTUM ONSET ANXIETY/PANIC DISORDER

- ☐ Symptoms include:
  - Sudden onset (usually within 10 seconds) of anxiety, fear
  - At least four of these symptoms: rapid breathing; rapid heart rate, palpitations; tight chest or throat; nausea or abdominal distress; fear of dying, going crazy or losing control
- ☐ Can present during pregnancy and in the early postpartum period
- ☐ Prevalence rates not reported
- ☐ Women with a history of anxiety/panic attacks prior to pregnancy have an increased risk for developing PPD
- ☐ History of anxiety/panic attacks pre-pregnancy warrant medical investigation to prevent problems during pregnancy with the mother and/or fetus

BABY BLUES

- ☐ Symptoms:
  - Bouts of crying with no specific reason
  - Impatience, irritability, restlessness, and anxiety
  - Temporary experience of mild depression
- ☐ Approximately 50 to 80 percent of women report having had some or all of the above-listed labile symptoms
- ☐ Symptoms usually disappear, but some women who experience the baby blues are at risk for developing PPD
- ☐ Occurs during the immediate first three days after birth and can last two to three weeks
- ☐ Considered hormonally related
- ☐ Women rarely pose any significant physical threat to themselves or to their babies

POSTPARTUM PSYCHOSIS

- ☐ Clinical features include:
  - Hallucinations
  - Delusions
  - Extreme agitation
  - Inability to sleep
  - Bizarre and irrational speech or behavior
- ☐ Occurs in one to two cases per 1,000 births
- ☐ Has a sudden onset, usually within the first week after birth
- ☐ Postpartum psychosis poses a threat to the woman or to her infant as she may have suicidal ideation, intent, and be at-risk for committing suicide or infanticide
- ☐ Associated risk factor of family or personal history of mood-swing disorders
- ☐ Hospitalization and aggressive treatment are critical
- ☐ Chemically similar to bipolar illness as they may have suicidal or homicidal ideation or intent

POSTTRAUMATIC STRESS DISORDER

- ☐ Characteristic symptoms include:
  - Persistent re-experiencing of the traumatic event
  - Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness
  - Persistent symptoms of increased arousal
- ☐ All of the above symptoms must be present for ≥ one month with impaired daily living ability
- ☐ Symptoms are usually evident within the first three months after the trauma (considered Acute PTSD), although longer time frames are not uncommon (Chronic PTSD)

This document reflects the consensus of the Indiana Perinatal Network (IPN) State Perinatal Advisory Board—a constituency of professional organizations (i.e. ACOG, AAP) and individuals (i.e. CNMs, MDs, consumers) committed to the belief that every baby in Indiana deserves to be born healthy and into a safe and nurturing home.

IPN documents such as this are intended to serve as recommendations—not as established standards or rigid rules. Healthcare providers must make the best decisions possible within the limitations of the particular situation. All are invited to make suggestions for improving this document.

TREATMENT/PHARMACOLOGIC INTERVENTIONS

Early treatment is found to hasten remission, remedy maternal-infant problems and reduce insecure infant attachment.

* A partial listing of medications is adapted from Sichel, D & Driscoll J (1999), *Women's Moods: What Every Woman Must Know About Hormones, the Brain and Emotional Health*, New York: Harper Collin Publishers.

POSTPARTUM DEPRESSION

Breastfeeding Guidelines for Women Receiving Antidepressants

- ☐ Balance the benefits of breastfeeding with the risks of not taking the medication
- ☐ Use the safest medication available
- ☐ Consider measuring the blood concentration in the nursing infant three weeks after medication is started; any question of toxicity demands a blood level from the baby
- ☐ Be familiar with the infant's behavior
- ☐ Instruct the mother to take the medication when the infant is least likely to be exposed to the drug
- ☐ Pump and discard the milk for one feeding to limit baby's exposure to drug secretion
- ☐ It often takes three to four weeks for an antidepressant to work
- ☐ Recommendations for antidepressant medication would be at least for six to nine months or longer, from the time the woman is feeling well
- ☐ Abrupt cessation of serotonin-enhancing medications may cause withdrawal symptoms ("serotonin discontinuation syndrome") such as dizziness, paraesthesia, tremor, anxiety, nausea and palpitations
- ☐ Fluoxetine usage has been associated with irritability, sleep disturbance and poor feeding in some breastfeeding infants

Antidepressants

- ☐ Selective Serotonin-reuptake inhibitors (SSRIs):
  - Lexapro (escitalopram)
  - Celexa (citalopram)
  - Zoloft (setraline)
  - Paxil (paroxetine)
  - Prozac (fluoxetine)
  - Luvox (fluvoxamine)
- ☐ Selective Serotonin- and Norepinephrine-reuptake inhibitors (SNRIs):
  - Effexor Effexor (venlafaxine)
  - Cymbalta (duloxetine)
- ☐ Tricyclics:
  - Tofranil (imipramine)
  - Norpramin (desipramine)
  - Aventyl (nortriptyline)
  - Elavil (amitriptyline)

- ☐ Hormone replacement
- ☐ Postpartum depression support groups
- ☐ Group psychotherapy
- ☐ Counseling/interpersonal psychotherapy
- ☐ Hospitalization when there are plans to harm oneself or the baby
- ☐ Electroconvulsive therapy (ECT)

Paxil, Luvox, Zoloft and Prozac not associated with birth defects or major problems during pregnancy

POSTPARTUM OBSESSIVE/COMPULSIVE DISORDER

Antianxiety medications

- ☐ Benzodiazepine medications:
  - Klonopin (clonazepam)
  - Ativan (lorazepam)
  - Xanax (alprazolam)
  - Serax (oxazepam)
  - Valium (diazepam)

Antidepressants

- ☐ SSRIs:
  - Prozac
  - Zoloft
  - Paxil
  - Luvox
  - Celexa
  - Lexapro
- ☐ Tricyclics:
  - Tofranil
  - Norpramin
  - Aventyl
  - Elavil

- ☐ Psychotherapy

- ☐ Cognitive-behavioral group therapy to learn strategies to help cope with obsessive thoughts and compulsive behaviors

- ☐ Postpartum depression support groups

POSTPARTUM ONSET PANIC DISORDER

Antianxiety medications

- ☐ Benzodiazepine medications:
  - Klonopin
  - Ativan
  - Xanax
  - Serax
  - Valium

Antidepressants

- ☐ SSRIs:
  - Prozac
  - Zoloft
  - Paxil
- ☐ SNRIs:
  - Effexor
  - Cymbalta
- ☐ Tricyclics:
  - Tofranil
  - Norpramin
  - Aventyl
  - Elavil

- ☐ Counseling/psychotherapy

- ☐ Postpartum depression support groups

Side Effects:

- ☐ Klonopin, Ativan, Serax and Valium may increase chance of cleft lip or palate if taken in the first trimester
- ☐ Klonopin or other Benzodiazepine medications taken in pregnancy may cause minor problems in the newborn such as breathing difficulties, sleepiness, lethargy, or slow sucking, as well as intoxication and/or withdrawal. Symptoms recede in a few days with no long-lasting effects

POSTPARTUM PSYCHOSIS

Mood Stabilizers:

- ☐ Lithium– immediately after birth (also the safest of mood stabilizers when given in the first trimester)
- ☐ Depakote (effective mood stabilizing medication)
- ☐ Tegretol (carbamazepine)

Antipsychotics:

- ☐ Thorazine (chlorpromazine)
- ☐ Zyprexa (olanzapine)
- ☐ Risperdal (risperidone) May combine lithium and antipsychotics
- ☐ Can supplement the mood stablilizer with one of the newer antipsychotic agents:
  - Zyprexa
  - Risperdal
  - Seroquel (quetiapine)

- ☐ Mood stabilizers take at least two weeks or longer to show significant effect, so the need for an antipsychotic is probably quite high if you wait

- ☐ Counseling/psychotherapy

- ☐ Hospitalization when there are plans to harm oneself or the baby

- ☐ Electroconvulsive therapy (ECT)

POSTTRAUMATIC STRESS DISORDER

Antidepressants

- ☐ SSRIs:
  - Prozac
  - Zoloft
  - Paxil
  - Luvox
  - Celexa
  - Lexapro

Primary Prevention:

- ☐ Careful history taking
- ☐ Examining birthing alternatives
- ☐ Discuss birthing expectations

Secondary Prevention:

- ☐ Screening women postdelivery for PTSD

Tertiary Prevention:

- ☐ Long term follow-up so that treatment is delivered to women, in combination with their families, who have developed chronic PTSD

- ☐ Cognitive-behavioral therapy

- ☐ Support groups

- ☐ Eye Movement Desensitization and Reprogramming (EMDR)

- ☐ Image habituation therapy

- ☐ Relaxation with or without biofeedback

SCREENING OPTIONS FOR PERINATAL DEPRESSION

BECK'S POSTPARTUM DEPRESSION SCREENING SCALE (PDSS)

- ☐ Can be administered two weeks postpartum
- ☐ Is a 35-item Likert response self-report scale
- ☐ Takes five to ten minutes to administer and provides an overall severity score
- ☐ Asks women to rate how they have been feeling over the past two weeks
- ☐ Has a specificity of 98 percent; a sensitivity of 94 percent; and a positive predictive value of 90 percent
- ☐ Designed to assess the presence, severity and type of PPD symptoms
- ☐ Consists of seven symptom areas: Sleeping/Eating Disturbances, Anxiety/Insecurity, Emotional Lability, Mental Confusion, Loss of Self, Guilt/Shame and Suicidal Thoughts
- ☐ When time is limited, the first seven items function as a short form, which can be completed in two minutes, with item 7 sensitive to suicidal thinking
- ☐ If the score on either the short or long form is WNL, recommendations are to administer either form every three months during the first year postpartum

EDINBURGH POSTNATAL DEPRESSION SCALE (EPDS)

- ☐ Contains 10 short statements of common depressive symptoms
- ☐ Uses a Likert-type scale for responses whereby the mother chooses the best response to how she has been feeling in the past week
- ☐ Has a specificity of 92.5 percent, a sensitivity of 88 percent and a positive predictive value of 73 percent
- ☐ Is a self-report questionnaire and can be administered anytime during the pregnancy or postpartum period
- ☐ Cannot be used in the prenatal period to screen for postpartum depression

CENTER FOR EPIDEMIOLOGIC STUDIES—DEPRESSION (CES-D) SCALE

- ☐ Developed specifically to identify depression in the general population
- ☐ Contains 20 items to assess symptoms experienced during the prior week
- ☐ Items evaluated are in agreement with the criteria for depression given in the Diagnostic & Statistical Manual of Mental Disorders (DSM-IV)
- ☐ Used in the prenatal period to screen for postpartum depression.
- ☐ A score of 16 or above indicates depression

ANTENATAL PSYCHOSOCIAL HEALTH ASSESSMENT TOOL

- ☐ Assess psychosocial risk factors during pregnancy
- ☐ A self-report tool with 45 questions that have either a five-point rating scale or are open-ended.
- ☐ Takes approximately 20 minutes to complete
- ☐ Highly recommended for use by public health nurses and home visitors in the assessment of all primiparous women and all high-risk multiparous women
- ☐ Available upon request from the author deana.midmer@utoronto.ca

RESOURCES

- ☐ American College of Obstetricians & Gynecologists (ACOG)
  409 12th Street, SW
  Washington, D.C. 20024-2188
  Phone: 202.484.3321
  Fax: 202.479.6826
  Website: www.acog.com

- ☐ American Academy of Family Physicians (AAFP)
  11400 Tomahawk Creek Pkwy
  Leawood, KS 66211-2672
  Phone: 913.906.6000
  Website: www.aafp.org

- ☐ American Psychological Association (APA)
  750 First Street, N.E.
  Washington, D.C. 20002-4242
  Phone: 202.336.5700 or 800.374.2721
  Website: www.apa.org

- ☐ Office on Women's Health (OWH)
  200 Independence Avenue, S.W.
  730B
  Washington, D.C. 20201
  Website: www.4woman.gov

- ☐ Association of Women's Health, Obstetric, and Neonatal Nurses (AWHONN)
  2000 L Street, N.W., Suite 740
  Washington, D.C., 20036
  Phone: 202.261.2400
  Fax: 202.728.0575
  Website: www.awhonn.org

- ☐ Depression After Delivery (DAD)
  Website: www.depressionafterdelivery.com

- ☐ Postpartum Support International (PSI)
  927 North Kellogg Avenue
  Santa Barbara, CA 93111
  Phone: 805.967.9367
  Fax: 805.967.0608
  Website: www.postpartum.net

- ☐ Pacific Postpartum Support Society
  104-1416 Commercial Drive
  Vancouver, BC V5L 3X9 CANADA
  Phone: 604.255.7999
  Fax: 604.255.7588
  Website: www.postpartum.org
  E-Mail: pppss@postpartum.org

- ☐ Postpartum Education for Parents (PEP)
  P.O. Box 6154
  Santa Barbara, CA 93160
  Phone: (805) 564-3888
  Website: www.sbpep.org

Online PPD Support Groups

- www.ppdsupportpage.com
- www.storknetfamily.com
- www.depressionafterdelivery.com
- www.parentsplace.com
- www.babycenter.com
- www.postpartumstress.com
- www.postpartumdads.org

- http://www.medscape.com/medscape/cro/1999/APA/Sory

- http://www/medscape.com/medscape/womansHealth/jou…/ref-wh3062 (Psychiatric medications in the breastfeeding woman)

- www.pndinfo.co.uk/pnd.htm Postnatal (Depression information for men)