# THE PERISCOPE PROJECT

PERINATAL SPECIALTY CONSULT PSYCHIATRY EXTENSION

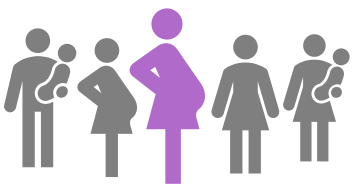
This toolkit was produced by the Medical College of Wisconsin and is provided to health care providers through The Periscope Project. The goal of this toolkit is to provide practitioners with an up-to-date, reliable, and easy to use source of information for mental health conditions during the perinatal period. The content is based on the latest available evidence-based guidelines and research whenever possible. If you are aware of new guidelines or research or if you have suggestions that can help improve this toolkit, please contact ThePeriscopeProject@mcw.edu. Please read our disclaimer before using our toolkit.

**This toolkit is for educational purposes only and does not constitute medical advice. The toolkit is not a replacement for careful medical judgments by qualified medical personnel. There may be information in the toolkit that does not apply to or may be inappropriate for the medical situation at hand.**

# Evaluating Mood Symptoms

| Baby Blues | Perinatal Depression | Bipolar Disorder | Psychosis |
|---|---|---|---|
| **A common, temporary phenomenon with prominent mood swings in the immediate postpartum period. **An independent risk factor for postpartum depression, especially if symptoms are more severe.*** <br>✦ *Onset*: Typically in the first week following delivery. <br>✦ *Duration*: No more than 2 weeks. <br>*Signs/Symptoms*: Tearfulness, excessive worrying, mood swings, irritability, difficulties sleeping, changes in appetite. <br>*Treatment*: Will likely resolve naturally without formal intervention. Encourage participation in support groups, asking for help when needed, and healthy self-care practices. | **An episode of major depression occurring in the context of pregnancy and/or the postpartum period.** <br>✦ *Onset*: During pregnancy, or up to 1 year postpartum. <br>✦ *Duration*: May persist until treated. <br>*Signs/Symptoms*: Depressed mood, loss of interest in all/most activities, changes in appetite, changes in sleep habits, excessive guilt and/or worry, impaired concentration, recurrent thoughts of death or suicidal ideation. <br>*Treatment*: Therapy, medications. Encourage participation in support groups, asking for help when needed, and healthy self-care practices. | **A mood disorder consisting of both depressive symptoms as well as mania.** <br>✦ *Onset*: Prior to pregnancy, during pregnancy, or in the postpartum period (often precipitated by disturbed sleep). <br>✦ *Duration*: Persists until treated. <br>*Signs/Symptoms*: May present with depressive symptoms, as previously delineated. Mania characterized by a decreased need for sleep, risk-taking behaviors (e.g., gambling, promiscuity), euphoria or irritability, increased goal-directed activity, grandiosity. <br>*Treatment*: Medications, therapy. Inpatient hospitalization may be indicated if symptoms are severe and are associated with psychosis. Encourage participation in support groups, asking for help when needed, and healthy self-care practices (most importantly, **sleep hygiene**). | ***A psychiatric emergency consisting of notable changes in mental status, typically associated with severe mood symptoms (depression, mania, or a mixed mood episode). Prominent symptoms include delusions, hallucinations, and/or confusion.*** <br>Onset is sudden and deterioration is rapid. Most commonly, onset occurs within 2-12 weeks of delivery, often on days 1-3 postpartum. <br>*Prevalence*: This is a rare complication of pregnancy, occurring in 1-2 women/1,000 births. <br>*Risk Factors*: History of bipolar disorder, a previous episode of psychosis (especially in the postpartum period). <br>*Treatment*: Inpatient hospitalization is usually indicated in these cases. |

## How *Common* are Mood Symptoms During/After Pregnancy?



**1 in 5**

*Pregnant or postpartum patients will be affected by depression in the perinatal period.*

***50-85%*** will experience symptoms of Baby Blues
***2-3%*** will display symptoms of Bipolar Disorder

## Who is at risk?

- Personal or family history of a mood disorder
- Lack of social support
- Low socioeconomic status
- History of trauma
- Current domestic violence and/or relationship discord
- Multiple births
- Chronic/medical illness

*References*:
Howard LM, Molyneaux E, Dennis CL, Rochat T, Stein A, Milgrom J. (2014). Non-psychotic mental disorders in the perinatal period. *Lancet*, 384(9956), 1775-88.
Jones I, Chandra PS, Dazzan P, Howard LM. (2014). Bipolar disorder, affective psychosis, and schizophrenia in pregnancy and the post-partum period. *Lancet*, 384(9956),1789-99.
Yonkers KA, Vigod S, Ross LE. (2011). Diagnosis, pathophysiology, and management of mood disorders in pregnant and postpartum women. *Obstet Gynecol*, 117, 961–77.

# Evaluating Anxiety, OCD, and PTSD

| Perinatal Anxiety | Obsessive Compulsive Disorder | PTSD |
|---|---|---|
| **A spectrum of anxiety symptoms occurring during pregnancy and/or the postpartum period. *Anxiety may occur in conjunction with perinatal depressive symptoms (usually a more severe illness, and more difficult to treat), or independently of mood disturbances.***<br>✦ *Onset*: If anxiety symptoms present during pregnancy, they most commonly present in the first trimester. If onset is postpartum, symptoms may present in the first 2 weeks to 6 months following delivery.<br>✦ *Duration*: May persist until treated.<br>*Prevalence*: An estimated 8.5%-13% of women experience an anxiety spectrum disorder in the postpartum period.<br>*Signs/Symptoms*: Persistent and excessive worries (especially about baby's health/safety/well-being), inability to relax, physiological arousal (palpitations/chest pain, air hunger, diaphoresis, dizziness, etc.).<br>*Treatment*: Therapy, medications. Encourage participation in support groups, asking for help when needed, and healthy self-care practices. | **A disorder characterized by repeated, intrusive obsessive thoughts that are often accompanied by compulsive behaviors performed to relieve anxiety associated with the intrusive thoughts. Patients will recognize the thoughts as being irrational and are often fearful of or distressed by them.**<br>✦ *Onset*: Prior to pregnancy, during pregnancy, or up to 1 year postpartum.<br>✦ *Duration*: May persist until treated.<br>*Prevalence*: 4% of women.<br>*Signs/Symptoms*: Disturbing repetitive thoughts that are recognized as irrational (e.g: thoughts of harming the baby); compulsive behaviors often involve behaviors dedicated to protecting the baby (e.g., frequent checking, hand washing, etc.).<br>*Treatment*: Often, a combination of ERP, CBT-oriented therapy and medications are more effective than a singular treatment approach. Encourage participation in support groups, asking for help when needed, and healthy self-care practices. | **A disorder precipitated by a traumatic experience (including a history of traumatic birth). *Preexisting PTSD may also be exacerbated during the perinatal period.***<br>✦ *Onset*: May be present prior to pregnancy or result from a traumatic birth experience.<br>✦ *Duration*: May persist until treated.<br>*Prevalence*: Affects an estimated 2-15% of women.<br>*Signs/Symptoms*: Syndrome that may include nightmares, hyperarousal, pervasive thoughts or re-experiencing of past trauma, irritable mood, the tendency to avoid disturbing stimuli, physiological arousal symptoms.<br>*Treatment*: Therapy, medications. Encourage participation in support groups, asking for help when needed, and healthy self-care practices. |

## Is It Important to Distinguish Between Perinatal Depression and Perinatal Anxiety?

☛ **Studies have demonstrated that individuals struggling with perinatal depression will frequently present with significant anxiety symptoms**

☛ **Nearly half of all postpartum patients experience obsessions and compulsions– the majority of which do not represent overt OCD but rather may signal perinatal anxiety and/or depression**

☛ **Detecting comorbid anxiety symptoms will facilitate appropriate and targeted treatment recommendations (SSRIs are effective for both anxiety and depressive symptoms) and confer better outcomes for both patient and baby.**

## Who is at risk?

- Personal or family history of an anxiety disorder
- Lack of social support
- Low socioeconomic status
- History of trauma
- Current domestic violence and/or relationship discord
- Multiple births
- Prior pregnancy loss

*References*:
Miller ES, Hoxha D, Wisner KL, Gossett DR. (2015). The impact of perinatal depression on the evolution of anxiety and obsessive-compulsive symptoms. *Arch Womens Ment Health*, 18(3), 457-61.
Wisner KL, Peindl KS, et al. (1999).Obsessions and compulsions in women with postpartum depression. *J Clin Psychiatry*, 60(3), 176-80.