Sweet Miracles llc

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Evaluation and Management of Postpartum Mood Disorders (PPMD):

1. Definition or Key Clinical Information*: (ADAA, n.d.)*

"The high hormonal changes and fluctuations that occur during and after childbirth could cause mothers to feel intense mood swings called "the baby blues" which affects 80% of mothers. If symptoms persist for more than a couple weeks, then it could potentially be something more severe, such as a postpartum disorder" (ADAA, n.d.). These disorders include Postpartum depression (PPD) in about 13% of birthers, Obsessive Compulsive Disorder (OCD) 3-5% of birthers, Post-traumatic stress disorder (PTSD) 9% of birthers, Postpartum Anxiety (PPA) in about 10% of birthers, and Postpartum Psychosis (PPP) is less than .01% or about 1-2 out of 1000 birthers (ADAA, n.d.).

2. Assessment *(King et al., 2018), (ADAA, n.d.)*

i. Risk Factors: *Previous hx of mood disorders, High ACE, EPDS, GAD7, or PHQ-9 scores, lack of social support, IPV, Significant life stressors, recent family or close personal losses, hx of sexual trauma, high-risk pregnancy, traumatic/complicated birth, anemia, smoking in pregnancy, poor nutrition, inadequate sleep, lack of support system, lack of community, financial stress, hormone imbalances, and many individual factors. No risk factors could be present, and PPMDs can still occur.*

ii. Subjective Symptoms (*ADAA, n.d.)*, (Cleveland Clinic, n.d.), (Langan and Goodbred, 2016)

PPD*: Sad mood, Crying, Loss of interest or pleasure in things that you normally enjoy, Fatigue or loss of energy, Appetite increase or decrease, Sleeping too much or insomnia, Feeling restless or as though you are slowed down, Feelings of worthlessness or excessive guilt, Difficulty concentrating or indecisiveness, Thoughts of death or suicide or a suicide plan, Anxiety and ruminating thoughts, which may occur with other mood symptoms.*

OCD*: Obsessions, also called intrusive thoughts, which are persistent, repetitive thoughts or mental images related to the baby. These thoughts are very upsetting and not something the woman has ever experienced before. Compulsions, where the mom may do certain things over and over again to reduce her fears and obsessions. This may include things like needing to clean constantly, check things many times, count or reorder things, A sense of horror about the obsessions, Fear of being left alone with the infant, Hypervigilance in protecting the infant, and Moms with postpartum OCD know that their thoughts are bizarre and are very unlikely to ever act on them.*

PTSD: *Intrusive re-experiencing of a past traumatic event (which in this case may have been the childbirth itself), Flashbacks or nightmares, Avoidance of stimuli associated with the event, including thoughts, feelings, people, places, and details of the event, Persistent increased arousal (irritability, difficulty sleeping, hypervigilance, exaggerated startle response), Anxiety and panic attacks, Feeling a sense of unreality and detachment.*

PPA: *Constant worry, Feeling that something bad is going to happen, Racing thoughts, Disturbances of sleep and appetite, Inability to sit still, Physical symptoms like dizziness, hot flashes, and nausea, and inability to do certain tasks or activities due to fears of bad things happening or changing daily habits such as taking all the knives out of the house for fear one may fall on the baby.*

PPP: *Anxiety or panic, Delusions, hallucinations, Depression, Feelings of guilt, Loss of appetite, Loss of enjoyment related to things they usually enjoy (anhedonia), Thoughts of self-harm, suicide or harming their child, Agitation or irritability, Disruptive or aggressive behavior, Talking more or faster than usual (or both), Needing less sleep, Delusions of greatness or importance (such as believing your child to be a holy or religious figure), Disorganized speaking or behavior, Disorientation or confusion, Disturbance of consciousness, and Catatonia and mutism (Being completely silent).*

iii. Objective Signs: *Impaired capacity to function, inability to answer questions, hard time focusing, slurred or slowed speech, confusion, memory gaps or loss, nervous repetitive motions such as hand wringing, pacing, leg bouncing, not sitting still, elevated emotions of sadness, anger, signs of distress crying, evidence of self-harm, disinterested in baby, not attempting to care for baby, don't acknowledge baby, vocalizes concerns related to being a bad parent or worried for baby, repetitive actions reported, etc.*

iv. Clinical Impressions *Midwives should be aware of these disorders and screen for them at every postpartum visit, but can not diagnose. Knowing what needs immediate care vs. F/U is important as some can be life-threatening to the birther or the baby if left untreated. Getting to know your client during pregnancy and what is normal for them can help identify changes in the postpartum. Some postpartum medications may not be safe for pregnancy and should be discussed with their provider. The benefits may outweigh the risks with severe enough symptoms. These patients may need additional postpartum visits.*

v. Clinical Test Considerations *EPDS screening, GAD7 screening, PHQ-9 Screening at every postpartum visit. The M-3 checklist (King et al., 2018), and labs for hormone, iron, thyroid, and some vitamin levels. Thyroid functions such as TSH, TPO/TPA, T4, T3, estrogen, progesterone or cortisol for hormones, CBC, and Ferritin for Anemia, and if they desired Vitamin D.*

iv. Differential Diagnosis *Baby blues, bipolar disorder, schizophrenia, substance use disorder, and medical conditions such as Chronic Fatigue Syndrome, Lyme Disease, Thyroid Disorder, Obstructive Sleep Apnea, and Neuroendocrine Tumors can all be mistaken for mental illness.*

3. Management plan *(ADAA, n.d.), (King et al., 2018) (Motherlove Herbal Company, n.d.)*

i. Therapeutic measures to consider within the CPM scope

Light therapy, Self-care, journaling, increased nutrition protein and healthy fats, help lines, community connections and support groups, state financial assistance, food assistance such as WIC or EBT, encouraging bonding with baby and partner, safety plan, resources to leave unsafe situations, Acupuncture, Aromatherapy, meditation, heat therapy (warm bath, sauna), holding space for processing, Calms Forte by hyland, adequate sleep, lactation assistance if going poorly. Homeopathics include Cimicifuga, Cocculus, Ignatia, Pulsatilla, and Sepia. Herbs include Vitex, Motherwort, Lemon Balm, Skullcap, Oats, Chamomile, Valerian, and St. Johns Wort. Supplements include Omega-3, Vitamin D, Calcium, Magnesium, and Folic Acid. Bach Flower essences are Rescue Remedy, Gorse, Mustard, and Sweet Chestnut.

ii. Therapeutic measures commonly used by other practitioners

Interpersonal therapy is indicated for depression. Cognitive behavioral therapy is indicated for depression, anxiety disorders, eating disorders, and phobias. Exposure therapy is indicated for OCD and depression. Dialectical behavioral therapy is indicated for panic disorders, PTSD, eating disorders, and OCD. EMDR is indicated for PTSD, panic attacks, and phobias. Medications include SSRIs or SNRIs such as Lexapro, fluoxetine, citalopram, valproate, and carbamazepine. Brexanolone is used for depression. Antipsychotics such as clozapine should be restricted in use but are an option for certain cases.

iii. Ongoing Care *PPP is the only mood disorder that should immediately leave our care, but if under control in the postpartum window, continue a F/U visit for closure and additional referrals and guidance as needed. All other PPMD should be F/U on at each visit for progress, new needs, worsening symptoms, emotional screens, and new recommendations or plans of treatment to ensure safety for both the birther and the family. More frequent postpartum visits should be scheduled up to seeing them weekly.*

iv. Indications for Consult, Collaboration, or Referral *The patient will need to be referred for all outside therapy treatments and counseling to counselors and therapists, medication prescription, and possibly further hormone testing, and thyroid management to a PCP. If there is a concern for self-harm or harm to another or baby, a trained psychiatric professional should be involved and referred to handle the situation or call 911 if a situation is already happening.*

v. Client and family education: *Clients should be educated about the signs and symptoms of each, what to watch out for, and when to report symptoms. Usually, the family notices something going on, so it is important to educate more than just the birthing person. I provide a handout on how to reach out and about perinatal mood disorders. They also must know you are a mandated reporter if situations where safety is concerned, are involved. A self-care and postpartum plan could be made during pregnancy or postpartum to support limiting risk factors and make postpartum easier, along with establishing early care for a PCP and a therapist due to community access problems delaying care in some cases.*

References

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