Perinatal Mental Health Assessment and Management Guide

A Comprehensive Guide for Psychiatric Providers

Purpose: This guide provides psychiatric nurse practitioners, physician assistants, and other mental health clinicians with evidence-based approaches to assessing and treating mental health disorders during pregnancy and the postpartum period, with special attention to maternal and infant safety, risk assessment, and collaborative care.

Introduction

Perinatal mental health disorders are among the most common complications of pregnancy and the postpartum period, affecting up to 20% of women. These conditions can have profound and lasting effects on maternal well-being, mother infant bonding, child development, and family functioning. Despite their prevalence and impact, perinatal mental health disorders remain underdiagnosed and undertreated, with fewer than half of affected women receiving appropriate care. This guide provides psychiatric nurse practitioners, physician assistants, and other mental health clinicians with evidence based approaches to screening, assessment, and management of mental health disorders during pregnancy and the postpartum period. Special attention is given to risk-benefit decision-making regarding treatment options, collaborative care models, and the unique psychosocial factors affecting this population.

The perinatal period represents both a time of increased vulnerability for mental health disorders and a critical opportunity for intervention. Effective treatment not only

alleviates maternal suffering but also has the potential to prevent adverse outcomes for children and families. By implementing the approaches outlined in this guide, clinicians can provide more effective, evidence-based care for this important population.

Screening and Assessment

Comprehensive screening and assessment are essential for early identification and appropriate management of perinatal mental health disorders. Universal screening is recommended at multiple time points throughout pregnancy and the postpartum period.

Recommended Screening Schedule

During pregnancy: - Initial prenatal visit - Each trimester - High risk monitoring for women with: - History of depression or anxiety - Current psychosocial stressors - Complications of pregnancy - History of perinatal loss - Prior traumatic birth experience **Postpartum period:** - 2-week postpartum visit - 6-week postpartum visit - 3-month well-child visit - 6-month well child visit - 12-month well-child visit

Clinical Pearl:

Integrate mental health screening into routine prenatal and postpartum care by partnering with obstetricians, midwives, and pediatricians. Provide education about screening tools and create clear referral pathways to ensure women who screen positive receive timely mental health assessment. Consider implementing collaborative care models where psychiatric providers consult with obstetric practices to support screening and treatment initiatives.

Validated Screening Tools

Depression screening: - Edinburgh Postnatal Depression Scale (EPDS) - 10-item self-report measure - Validated for both prenatal and postpartum use - Cutoff score ≥13 indicates possible major depression - Includes anxiety items and a self harm question - Available in multiple languages - Takes approximately 5 minutes to complete - Patient Health Questionnaire-9 (PHQ-9) - 9-item self-report measure - Cutoff score ≥10 indicates possible major depression - Not specifically designed for perinatal population but widely used - Takes approximately 5 minutes to complete

Edinburgh Postnatal Depression Scale

(EPDS) Scoring Guide:

Screening Tools Icon

Instructions: The mother is asked to underline the response that comes closest to how she has been feeling in the previous 7 days. **Scoring:** - Questions 1, 2, & 4: Scored 0, 1, 2, or 3 with top response scored as 0 and bottom response scored as 3 - Questions 3, 5-10: Reverse scored with top response scored as 3 and bottom response scored as 0 - Maximum score: 30 - Cutoff scores: - ≥10: Possible depression (higher sensitivity) - ≥13: Probable depression (higher specificity) - Item 10 > 0: Requires immediate assessment for suicidal thoughts **Key considerations:** - The EPDS includes anxiety items (questions 3, 4, 5) - Question 10 specifically addresses thoughts of self-harm - A positive screen is not diagnostic but indicates need for further assessment - Cultural factors may affect optimal cutoff scores

Anxiety screening: - Generalized Anxiety Disorder 7-item scale (GAD-7) - 7-item self report measure - Cutoff score ≥10 indicates moderate anxiety - Takes approximately 3 minutes to complete

- Perinatal Anxiety Screening Scale (PASS)
- 31-item self-report measure specifically designed for perinatal anxiety •
  Assesses four domains: acute anxiety, general worry, perfectionism, and social anxiety
- Cutoff score ≥26 indicates clinically significant anxiety
- Takes approximately 10 minutes to complete

Bipolar disorder screening: - Mood Disorder Questionnaire (MDQ) - 13-item self-report measure - Screens for lifetime history of manic or hypomanic symptoms - Important to screen before initiating antidepressants - Takes approximately 5 minutes to complete - Bipolar Spectrum Diagnostic Scale (BSDS) - Narrative-based self-report measure - May have better sensitivity for bipolar II disorder - Takes approximately 5 minutes to complete

Post-traumatic stress disorder screening: - PTSD Checklist for DSM-5 (PCL-5) - 20-item self report measure - Cutoff score ≥33 suggests possible PTSD - Takes approximately 5-10 minutes to complete - Perinatal Post Traumatic Stress Disorder Questionnaire (PPQ) - 14-item self report measure specifically designed for birth-related trauma - Cutoff score ≥19 indicates significant symptoms - Takes approximately 5 minutes to complete

Clinical Pearl:

Always screen for bipolar disorder before initiating antidepressant treatment in the perinatal period. Undiagnosed bipolar disorder treated with antidepressant monotherapy can lead to mood destabilization, including induction of mania or rapid cycling. The postpartum period is a time of particularly high risk for first onset or recurrence of bipolar disorder, with postpartum psychosis representing a psychiatric emergency that requires immediate intervention.

Comprehensive Assessment Components

Psychiatric history: - Previous episodes of mental illness - Family history of psychiatric disorders - Previous perinatal mental health episodes - Prior treatment response - History of suicide attempts or

self-harm - Substance use history - Trauma history **Current symptoms assessment:** - Onset, duration, and severity of symptoms - Impact on functioning - Sleep patterns - Appetite and weight changes - Energy level - Concentration - Psychotic symptoms - Thoughts of self-harm or infant harm History Icon

Obstetric and medical history: - Current pregnancy status and gestational age - Pregnancy complications - Previous pregnancy outcomes - Medical comorbidities - Current medications - Allergies - Sleep disorders - Thyroid function - Anemia

Psychosocial assessment: - Social support system - Relationship quality - Financial stressors - Housing stability - Employment status - Childcare resources - History of intimate partner violence - Cultural factors affecting perinatal experience - Previous parenting experiences - Attitudes and expectations about pregnancy/parenting **Risk assessment:** - Suicidal ideation, intent, plan, and means - Thoughts of infant harm - Safety of home environment - Capacity for self-care - Capacity for infant care - Access to support and resources - Substance use - Intimate partner violence

Risk Assessment for Thoughts of Infant Harm:

Thoughts of infant harm exist on a spectrum and require careful assessment: **1. Intrusive thoughts of accidental harm:** - Common and not indicative of risk - Ego dystonic (distressing to the mother) - Mother takes protective actions - No psychotic features - Example: Intrusive thoughts of dropping the baby accompanied by increased vigilance **2. Unwanted thoughts of intentional harm:** - Moderately common - Ego-dystonic (distressing to the mother) - No intent to act on thoughts - No psychotic features - Example: Fleeting thoughts of harming baby that cause distress and avoidance behaviors **3. Altruistic filicidal ideation:** - Uncommon and concerning - May be ego-syntonic (aligned with mother's belief system) - Based on belief that death would be better for the child - May occur with severe depression - Example: Thoughts that baby would be better off dead due to

perceived suffering **4. Psychotic thoughts of infant harm:** - Rare but dangerous - Based on delusions or hallucinations - May include command hallucinations - Requires immediate intervention - Example: Delusion that baby is possessed or command hallucinations to harm the baby **Assessment questions:** - "Sometimes new mothers have scary thoughts about their babies. Has this happened to you?" - "Have you had thoughts of harming your baby?" - "What are these thoughts like? How often do they occur?" - "Do you want to act on these thoughts?" - "Do you believe something bad about your baby that others don't see?" - "Do you hear voices telling you to do something to your baby?"

Perinatal Depression

Perinatal depression includes major and minor depressive episodes that occur during pregnancy or within the first year after delivery. It affects approximately 10-15% of women and requires specialized assessment and treatment approaches that balance maternal mental health with fetal/infant safety considerations.

Clinical Presentation

Common symptoms: - Persistent sadness or depressed mood - Anhedonia (loss of interest or pleasure) - Excessive guilt or worthlessness - Fatigue or loss of energy - Sleep disturbance (beyond normal pregnancy/postpartum disruptions) - Appetite changes - Concentration difficulties - Psychomotor agitation or retardation - Suicidal ideation **Perinatal-specific presentations:** - Excessive worry about infant health or safety - Intrusive thoughts of infant harm - Severe anxiety about parenting abilities - Difficulty bonding with infant - Excessive irritability or anger - Feeling overwhelmed by parenting demands - Ambivalence about motherhood - Grief about loss of pre-pregnancy identity

Differential Diagnosis:

Medical conditions to consider: - Thyroid dysfunction (particularly postpartum thyroiditis) - Anemia - Vitamin deficiencies (B12, folate, vitamin D) - Autoimmune disorders - Sleep apnea - Gestational diabetes or postpartum diabetes -

Postpartum hemorrhage sequelae **Other psychiatric conditions:** - Bipolar disorder (particularly postpartum) - Generalized anxiety disorder - Obsessive-compulsive disorder - Post traumatic stress disorder (including birth trauma) - Adjustment disorder - Bereavement (after pregnancy loss) **Normal postpartum experiences:** - "Baby blues" (transient mood lability in first 2 weeks postpartum) - Normal sleep deprivation - Normal adjustment to parenting role - Normal grief reactions to birth experiences that differ from expectations

Treatment Approaches

Psychotherapy: - Cognitive Behavioral Therapy (CBT) - Strong evidence for both prevention and treatment - Focuses on modifying negative thoughts about motherhood, self, and infant - Typically 8-12 sessions - Effective in individual and group formats - Interpersonal Psychotherapy (IPT) - Strong evidence for both prevention and treatment - Focuses on role transitions, interpersonal conflicts, grief, and social support - Typically 12-16 sessions - Particularly effective for postpartum depression - Other evidence-based approaches: - Behavioral activation - Mindfulness-based cognitive therapy - Mother-infant dyadic therapy - Supportive psychotherapy

Psychotherapy Adaptations for Perinatal Population:

Psychotherapy Icon

Practical adaptations: - Flexible scheduling to accommodate pregnancy/infant needs - Options for telehealth delivery - Inclusion of partners in select sessions - Childcare accommodations during sessions - Shorter, more frequent sessions if needed **Content adaptations:** - Focus on perinatal-specific concerns and transitions - Incorporation of infant care and parenting strategies - Attention to mother-infant attachment - Addressing realistic vs. idealized expectations of motherhood - Strategies for managing sleep disruption - Techniques for balancing

infant needs with self-care - Processing birth experiences, particularly traumatic births

Pharmacotherapy during pregnancy: - General principles: - Risk-benefit decision making is essential - Untreated depression poses risks to mother and fetus - Shared decision making with thorough informed consent - Coordination with obstetric providers - Monotherapy preferred when possible - Stable medications generally preferred over switching - Lowest effective dose while maintaining remission - First-line antidepressants: - SSRIs: sertraline, citalopram, escitalopram - Most data available for safety - Small increased risk of PPHN with late pregnancy exposure (0.3% to 1%) - Transient neonatal adaptation syndrome possible - No consistent evidence for major congenital malformations - SNRIs: venlafaxine, duloxetine - Less data than SSRIs but generally considered acceptable options - Similar concerns regarding neonatal adaptation syndrome

Antidepressant Selection in Pregnancy:

Sertraline (Bérard et al., 2015)	First-line	Most data supporting safety; minimal placental transfer; effective for both depression and anxiety But it can cause some malformation like atrial or ventricular defect
Citalopram/ Escitalopram (Sivojelezova et al., 2005)	First-line	Well-studied; monitor QTc with higher doses; good tolerability
Fluoxetine	Second line	Long half-life; higher levels in breast milk; early studies suggested possible association with minor malformations
Paroxetine (Einarson, 2010)	Avoid initiating	Some studies suggest small increased risk of cardiac defects; difficult to discontinue due to withdrawal syndrome

Venlafaxine	Second line	Less data than SSRIs; consider for SSRI non responders; monitor blood pressure
Bupropion	Second line	Limited data; consider for depression with significant fatigue or SSRI-induced sexual dysfunction
Mirtazapine	Second line	Limited data; consider for depression with insomnia and poor appetite
TCAs (HUNTINGTON & ZANTOP, 2004)	Third-line	Anticholinergic effects; orthostatic hypotension; cardiac concerns; overdose toxicity
MAOIs (Burke et al., 2018)	Avoid	Dietary restrictions; potential hypertensive crisis with certain foods or medications

Pharmacotherapy during lactation: - General principles: - Most antidepressants are compatible with breastfeeding - Infant exposure is typically much lower than during pregnancy - Consider infant age, health status, and proportion of diet from breast milk -
Monitor infants for sedation, feeding problems, or irritability - Timing medication dose immediately after breastfeeding can minimize exposure

- • Preferred options during lactation:
- Sertraline: minimal transfer into breast milk
- Paroxetine: minimal transfer into breast milk (though not first-line in pregnancy) •
- Citalopram/escitalopram: generally acceptable levels in breast milk •
- Venlafaxine: moderate transfer but few adverse effects reported
- Avoid fluoxetine if possible due to long half-life and higher milk levels

Non-pharmacological biological treatments: - Bright light therapy - Effective for both antepartum and postpartum depression - 10,000 lux light for 30 minutes each morning - Particularly useful for depression with seasonal pattern - Minimal risk; main side effects are headache and eyestrain -

Exercise - Moderate evidence for prevention and treatment - 30 minutes of moderate activity most days - Can be adapted for pregnancy limitations - Additional benefits for general health and well-being - Omega-3 fatty acids - Mixed evidence but generally safe - EPA appears more effective than DHA - Typical doses: 1-2 g daily - Additional benefits for fetal neurodevelopment

Clinical Pearl:

For severe perinatal depression that has not responded to first-line treatments, consider referral for specialized treatments such as repetitive Transcranial Magnetic Stimulation (rTMS), which has demonstrated efficacy in perinatal depression with minimal risk. Electroconvulsive Therapy (ECT) remains an important option for severe, treatment-resistant depression, particularly with psychotic features or when the patient's life is at risk. ECT can be safely administered during all trimesters of pregnancy with appropriate obstetric monitoring and anesthesia modifications.

Severe or treatment-resistant depression: - Repetitive Transcranial Magnetic Stimulation (rTMS) - Evidence supports efficacy in perinatal depression - No anesthesia required - Typically 20-30 sessions over 4-6 weeks - Main contraindication is history of seizures

- Electroconvulsive Therapy (ECT)
- Highly effective for severe depression • Can be safely administered during pregnancy with appropriate precautions • First-line for depression with psychotic features or high suicide risk
- Requires anesthesia and specialized treatment team
- Brexanolone (Zulresso)
- FDA-approved specifically for postpartum depression • Administered as 60-hour IV infusion in monitored setting

- Rapid onset of action (within days)
- REMS program requires specialized certification •
  Contraindicated during pregnancy and requires cessation of breastfeeding during administration

Perinatal Anxiety Disorders

Anxiety disorders are common during the perinatal period and include

Anxiety Icon

generalized anxiety disorder, panic disorder, social anxiety disorder, and specific phobias. These conditions often co-occur with depression and require specific assessment and treatment approaches.

Clinical Presentation

Common symptoms: - Excessive worry that is difficult to control - Restlessness or feeling keyed up - Fatigue - Difficulty concentrating - Irritability - Muscle tension - Sleep disturbance - Panic attacks **Perinatal-specific presentations:** - Excessive worry about fetal/infant health and development - Intense fear of childbirth (tokophobia) - Extreme fear of harm coming to the baby - Hypervigilance about infant safety - Excessive concern about parenting abilities - Intrusive thoughts of accidental harm to infant - Avoidance of infant care due to anxiety - Somatic symptoms attributed to pregnancy complications

Distinguishing Perinatal Anxiety from Normal Concerns:

Anxiety Icon

Intensity	Proportionate to situation	Excessive, overwhelming
Duration	Transient	Persistent, chronic
Control	Manageable	Difficult to control

Functional Impact	Minimal interference	Significant impairment

Reassurance	Effectively reassured	Temporary or no relief
Safety Behaviors	Reasonable precautions	Excessive checking, avoidance
Physical Symptoms	Minimal	Significant (tension, palpitations)

Treatment Approaches

Psychotherapy: - Cognitive Behavioral Therapy (CBT) - Strong evidence for perinatal anxiety disorders - Focuses on identifying and challenging anxious thoughts - Includes exposure techniques for avoidance behaviors - Typically 8-12 sessions - Effective in individual and group formats - Mindfulness-Based Cognitive Therapy (MBCT) - Combines mindfulness practices with cognitive techniques - Helps women relate differently to anxious thoughts - Particularly helpful for rumination - Typically 8 weekly sessions - Acceptance and Commitment Therapy (ACT) - Focuses on accepting anxious thoughts while committing to valued actions - Particularly helpful for anxiety about uncertainty - Emerging evidence for perinatal population

CBT Techniques for Perinatal Anxiety:
Psychotherapy Icon

Cognitive restructuring for common perinatal anxious thoughts: - "Something will go wrong with my pregnancy/baby" → Examine evidence, consider probability - "I won't be able to handle labor pain" → Challenge catastrophizing, develop coping strategies - "I'm not a good enough mother" → Identify perfectionism, develop realistic standards - "What if I accidentally harm my baby?" → Normalize intrusive thoughts, distinguish thoughts from actions **Behavioral techniques:** -

Gradual exposure to feared situations (e.g., being alone with baby, leaving baby with others) - Reduction of safety behaviors and reassurance seeking - Scheduled worry time to contain rumination - Relaxation training adapted for pregnancy (progressive muscle relaxation, guided imagery) - Breathing exercises safe for pregnancy - Sleep hygiene strategies compatible with infant care demands

Pharmacotherapy: - SSRIs and SNRIs - First-line pharmacotherapy for perinatal anxiety disorders - Same considerations as for perinatal depression - Sertraline, citalopram, and escitalopram preferred - May require higher doses for panic disorder - Benzodiazepines - Generally avoided for regular use during pregnancy - Short-term use may be considered for severe symptoms - Potential risks include: - Cleft lip/palate (first trimester exposure, small absolute risk) - Neonatal withdrawal syndrome - Floppy infant syndrome - If necessary, use lowest effective dose for shortest duration - Lorazepam or clonazepam preferred if needed - Hydroxyzine - Second-line for short-term anxiety management - Limited data but generally considered low risk - Non-addictive alternative to benzodiazepines - Main side effect is sedation

Clinical Pearl:

For women with panic disorder who are planning pregnancy, consider a gradual taper of benzodiazepines before conception if possible, with transition to an SSRI for maintenance treatment. For women already pregnant who are taking benzodiazepines, abrupt discontinuation is not recommended due to withdrawal risks. Instead, implement a slow taper while introducing an SSRI, with the goal of minimizing benzodiazepine exposure while maintaining symptom control. Provide psychotherapy concurrently to develop non-pharmacological coping strategies.

Non-pharmacological approaches: - Mindfulness meditation - Evidence supports efficacy for anxiety reduction - Can be practiced throughout pregnancy and postpartum - Brief practices (5-10 minutes) can be integrated into daily routine - Mobile apps can support home practice

- Relaxation techniques
- Progressive muscle relaxation (modified for pregnancy) •
  Guided imagery

• • • exercises

Deep breathing Body scanning

Acupuncture

- Some evidence for anxiety reduction
- Ensure practitioner has experience with pregnant women
- Generally considered safe when properly administered

- Exercise

- Regular, moderate exercise reduces anxiety symptoms •
Adapt to pregnancy limitations
- Yoga particularly beneficial (with pregnancy modifications)

Perinatal Obsessive-Compulsive Disorder

Perinatal obsessive-compulsive disorder (OCD) involves intrusive, unwanted thoughts (obsessions) and repetitive behaviors or mental acts (compulsions). The perinatal period is a time of increased risk for both new onset and exacerbation of existing OCD, with unique symptom presentations focused on infant harm.

Clinical Presentation

Common perinatal obsessions: - Intrusive thoughts of accidentally harming the baby - Intrusive thoughts of contaminating the baby - Excessive concerns about SIDS or infant illness - Intrusive sexual or religious thoughts about the baby - Fears of being an unfit parent - Excessive concerns about making the "wrong" parenting decision - Intrusive images of baby dead or injured - Fears of losing control around the baby

Common perinatal compulsions: - Excessive checking on the baby - Repeated cleaning or sterilizing - Avoiding caring for the baby - Seeking excessive reassurance about baby's health - Mental rituals (counting, praying, repeating phrases) - Excessive research about infant safety - Repeated confessing of intrusive thoughts - Arranging items in a specific order

Distinguishing OCD from Postpartum Psychosis:

Insight	Intact (recognizes thoughts as irrational)	Impaired or absent
Distress	Thoughts are ego-dystonic (distressing) Thoughts may be	ego-syntonic (aligned with beliefs)
Risk of Acting	Very low (takes precautions against thoughts)	Significant (may act on delusions)
Hallucinations	Absent	Often present
Thought Process	Organized, ruminative	Disorganized, illogical
Onset	Gradual	Rapid (days)
Mood	Anxious, distressed	Labile, euphoric, or severely depressed

Clinical implication: Women with perinatal OCD are often terrified of their intrusive thoughts and take excessive precautions to ensure they don't act on them, making them at very low risk of harming their infants. In contrast, women with postpartum psychosis may act on delusional beliefs about their infants and require immediate intervention.

Treatment Approaches

Psychotherapy: - Exposure and Response Prevention (ERP) - Gold standard treatment for OCD - Involves gradual exposure to feared situations while preventing compulsions - Typically 12-20 sessions - Requires specialized training to deliver effectively - Can be adapted for perinatal concerns - Cognitive Behavioral Therapy (CBT) - Focuses on challenging obsessional beliefs - Addresses thought-action fusion, perfectionism, and intolerance of uncertainty - Particularly helpful for obsessions without overt compulsions - Can be combined with ERP - Acceptance and Commitment Therapy (ACT) - Focuses on accepting intrusive thoughts while committing to valued actions - May be helpful for those who struggle with traditional ERP - Emerging evidence for OCD treatment

ERP Examples for Perinatal OCD:

For contamination fears: - Exposure: Touching "contaminated" objects then touching baby's items without washing - Response prevention: Refraining from excessive hand washing or cleaning **For harm obsessions:** - Exposure: Holding baby
near objects that trigger intrusive thoughts (e.g., knives, stairs) - Response prevention: Not seeking reassurance or engaging in mental rituals **For checking behaviors:** - Exposure: Leaving room while baby sleeps - Response prevention: Not returning to check repeatedly **For perfectionism about infant care:** - Exposure: Deliberately making minor "mistakes" in baby care routine - Response prevention: Not correcting or redoing the task **Implementation considerations:** - Begin with lower-anxiety exposures and progress gradually - Use imaginal exposure for high risk scenarios - Incorporate partner/family in exposure exercises when appropriate - Provide psychoeducation about normal intrusive thoughts in parenthood - Emphasize distinction between thoughts and actions

Pharmacotherapy: - SSRIs - First-line pharmacotherapy for perinatal OCD - Often requires higher doses than for depression - Longer duration to maximum effect (10-12 weeks) - Same considerations as for perinatal depression - Sertraline and fluoxetine have most evidence for OCD - Clomipramine - Tricyclic antidepressant with strong evidence for OCD - Second line due to side effect profile - Anticholinergic effects, orthostatic hypotension - Limited data in pregnancy but no

major malformation signal - Consider for SSRI-resistant cases - Augmentation strategies - Generally avoided during pregnancy if possible - Consider in severe, treatment-resistant cases - Options include: - Low-dose antipsychotics (with careful risk benefit assessment) - Glutamate modulators (limited pregnancy data)

Clinical Pearl:

Women with perinatal OCD often delay seeking treatment due to shame and fear of being reported to child protective services or having their baby removed. Provide clear education that intrusive thoughts about infant harm in OCD are common, distressing to the mother, and associated with extremely low risk of actual harm. Distinguish these ego-dystonic thoughts from intentions or desires to harm the infant. Create a safe, non-judgmental environment for disclosure, and clarify the limits of confidentiality regarding mandated reporting, emphasizing that OCD symptoms alone are not reportable concerns.

Integrated treatment approach: - Combined ERP and medication for moderate to severe OCD - Partner/family involvement in treatment - Psychoeducation for patient and family about OCD - Practical support to enable treatment participation - Coordination
with obstetric and pediatric providers - Postpartum planning for sleep management and symptom monitoring - Relapse prevention strategies

Perinatal Bipolar Disorder

Bipolar disorder in the perinatal period presents unique challenges for diagnosis and management. The postpartum period is a time of particularly high risk for mood episodes, including postpartum psychosis. Careful medication management is essential to balance maternal stability with fetal/infant safety.

Bipolar Icon

Clinical Considerations

Risk factors for perinatal recurrence: - Discontinuation of mood stabilizers - History of postpartum episodes - Bipolar I disorder (vs. Bipolar II) - Recent mood episode (within 2 years) -

First pregnancy - Sleep disruption - Family history of postpartum mood disorders - Psychosocial stressors **Postpartum risk period:** - Highest risk in first 4 weeks postpartum - Elevated risk continues through first year - Rapid onset of symptoms possible (days to weeks) - Sleep disruption as major trigger - Potential for rapid progression to severe symptoms

Postpartum Psychosis:

Key features: - Rapid onset (typically within 2 weeks postpartum) - Mood lability or severe depression - Disorganized thinking and behavior - Hallucinations (often command type) - Delusions (often regarding infant) - Confusion and disorientation - Sleep disturbance - Potential for harm to self or infant **Management:** - Psychiatric emergency requiring immediate intervention - Typically requires inpatient hospitalization - Mother-baby units ideal when available - Antipsychotics as first-line treatment - Mood stabilizers often indicated - ECT for severe or treatment-resistant cases - Close monitoring during recovery (6-12 months) - High risk of bipolar disorder diagnosis long-term **Risk factors:** - Personal or family history of bipolar disorder - Previous episode of postpartum psychosis (>50% recurrence) - Primiparity (first birth) - Sleep deprivation - Obstetric complications

Treatment Planning and Management

Preconception planning: - Comprehensive risk-benefit discussion - Optimization of mood stability before conception - Simplification of medication regimen when possible - Consideration of medication changes to lower-risk options - Folate supplementation (4mg daily with valproate or carbamazepine) - Development of monitoring plan during pregnancy - Discussion of postpartum relapse prevention strategies - Involvement of partner/support system in planning **Medication management principles:** - Maintain mood stability as primary goal - Untreated bipolar disorder poses significant risks - Monotherapy preferred when possible - Lowest effective dose while maintaining stability - Regular monitoring of symptoms and medication levels - Coordination with obstetric and pediatric providers - Detailed informed consent discussions - Shared decision-making approach

Mood Stabilizers in Pregnancy:

Planning Icon

Lithium (Poels et al., 2018)	- Increased risk of Ebstein's anomaly (0.05-0.1% vs. 0.005% baseline) - Requires dose adjustments as pregnancy progresses - Monitor levels monthly and weekly in third trimester - Reduce dose 24-48 hours before delivery - Risk of neonatal toxicity	- Moderate transfer into breast milk (24-72%) - Monitor infant lithium levels, thyroid, renal function - Watch for dehydration, lethargy, poor feeding - Compatible with caution and monitoring

Lamotrigine

- No significant increase in major malformations
- Possible small increased risk of oral clefts
- Clearance increases dramatically during pregnancy
- May require dose increases of 50-300%
- Monitor levels monthly
- Relatively high transfer into breast milk
- Generally well-tolerated by infants
- Monitor for rash, poor feeding, excessive sedation
- Compatible with breastfeeding

Valproate (Macfarlane & Greenhalgh, 2018)	- High teratogenic risk (10% major malformations) - Neural tube defects, cardiac defects, cleft palate - Neurodevelopmental effects (decreased IQ, autism risk) - Avoid in pregnancy if possible - If essential, use lowest effective dose, divided dosing	- Low transfer into breast milk (1-10%) - Monitor for sedation, poor feeding, liver dysfunction - Generally compatible with breastfeeding

Carbamazepine	- Increased risk of neural tube defects (0.5-1%) - Craniofacial defects, fingernail hypoplasia - Possible mild neurodevelopmental effects - Vitamin K deficiency in newborn - Clearance increases during pregnancy	- Low transfer into breast milk (7-10%) - Monitor for sedation, poor feeding, liver dysfunction - Generally compatible with breastfeeding

Antipsychotics in pregnancy: - Second-generation antipsychotics - No consistent evidence for major malformations - Metabolic effects (gestational diabetes, excessive weight gain) - Possible neonatal extrapyramidal symptoms - Most data available for quetiapine, olanzapine, risperidone - Monitor glucose, weight gain, blood pressure - First-generation antipsychotics - Longer history of use in pregnancy - No consistent evidence for major malformations - Extrapyramidal side effects - High-potency agents (haloperidol) often preferred - Limited data on comparative safety
Postpartum relapse prevention: - Prophylactic medication adjustment after delivery - Consider increasing mood stabilizer dose immediately postpartum - Restart medication promptly if discontinued during pregnancy - Close monitoring during first 3 months - Sleep management strategies - Shared nighttime infant care responsibilities - Consistent sleep-wake schedule - Protected sleep periods (4-hour minimum) - Temporary nighttime formula supplementation if breastfeeding - Brief naps during daytime

Clinical Pearl:

For women with bipolar disorder who wish to breastfeed, develop a detailed plan that balances the benefits of breastfeeding with the critical importance of maternal sleep and mood stability. Consider a combination feeding approach that allows for shared nighttime feedings and protected sleep periods for the mother. If mood symptoms begin to emerge, prioritize maternal sleep and consider transitioning to exclusive formula feeding temporarily until stability is reestablished. Remember that a stable mother is more important for infant

development than the feeding method.

Psychosocial interventions: - Interpersonal and Social Rhythm Therapy (IPSRT) - Focuses on regular daily routines and sleep patterns - Addresses interpersonal triggers for mood episodes - Particularly relevant during perinatal transitions - Can be adapted for perinatal population

- Family-Focused Therapy (FFT)
- Involves partners/family members in treatment
- Focuses on communication, problem-solving, and relapse prevention •
- Educates family about warning signs and intervention strategies
- Particularly helpful for postpartum support planning
- Psychoeducation
- Education about bipolar disorder and perinatal risks •
- Early warning sign identification
- Medication adherence support
- •
- management
- Sleep hygiene techniques strategies Stress

Collaborative Care and Resources

Effective perinatal mental health care requires collaboration among multiple providers and systems. Implementing collaborative care models and connecting patients with appropriate resources can significantly improve outcomes for mothers and infants.

Collaborative Care Models

Key components of collaborative care: - Systematic screening in obstetric settings - Psychiatric consultation for obstetric providers - Care coordination and case management - Measurement-based treatment to target - Stepped care approach based on symptom severity - Registry tracking of patients and outcomes - Evidence-based psychotherapy and pharmacotherapy **Benefits of collaborative care:** - Improved detection of perinatal mental health disorders - Increased access to treatment - Better treatment adherence - Improved clinical outcomes - Reduced stigma - More efficient use of specialist resources - Potential cost savings

Implementing Collaborative Care:

Steps for psychiatric providers: 1. Establish relationships with local obstetric practices 2. Offer education sessions on perinatal mental health for OB staff 3. Develop streamlined referral processes 4. Create shared documentation templates 5. Establish regular consultation times 6. Develop protocols for emergency situations 7. Provide feedback on referral outcomes 8. Track and share outcome data **Practical strategies:** - Embed psychiatric providers in obstetric settings when possible - Use telehealth for consultations when co-location not feasible - Develop
shared electronic health record access when possible - Create standardized screening and referral workflows - Establish clear communication channels for urgent concerns - Provide regular education updates on perinatal psychopharmacology

Key collaborators: - Obstetricians and midwives - Pediatricians and family physicians - Lactation consultants - Social workers - Case managers - Home visiting nurses - Doulas and birth workers - Early intervention specialists - Child protective services (when necessary) - Peer support specialists
Coordination of care strategies: - Obtain appropriate releases of information - Share treatment plans with relevant providers - Attend joint appointments when possible - Provide written recommendations for obstetric providers - Develop shared monitoring plans for medication management - Coordinate timing of psychiatric and obstetric appointments - Establish clear roles and responsibilities among providers - Create

emergency protocols with defined communication pathways

Patient Resources and Support

National organizations and hotlines: - Postpartum Support International (PSI) - Helpline: 1-800-944-4773 - Text support: 503-894-9453 - Provider directory and support groups - www.postpartum.net - National Maternal Mental Health Hotline - 1-833-943-5746 (24/7 support) - Text "MOM" to 741741 - National Suicide Prevention Lifeline - 988 or 1-800-273-8255 - Crisis text line: Text HOME to 741741 - Substance Abuse and Mental Health Services Administration (SAMHSA) - Treatment locator: 1-800-662-4357 - www.samhsa.gov/find-help

Online Resources for Patients:

Websites: - Postpartum Support International: www.postpartum.net - Maternal Mental Health NOW: www.maternalmentalhealthnow.org - Postpartum Progress: www.postpartumprogress.org - 2020 Mom: www.2020mom.org - The Blue Dot Project: www.thebluedotproject.org **Apps:** - MindMom: Mood tracking and resources for perinatal mental health - Expectful: Meditation and mindfulness for pregnancy and postpartum - What's Up: CBT-based tools for anxiety and depression - Happify: Science-based activities for emotional wellbeing - Breathe2Relax: Guided breathing exercises for stress management **Online therapy options:** - Postpartum Support International online support groups - The Motherhood Center virtual support groups - Maven Clinic virtual maternal mental health care - Talkspace and BetterHelp (therapists with perinatal specialization)

Support groups and peer support: - Postpartum Support International support groups - Hospital-based new mother groups - NAMI support groups - Local peer-led support groups - Online support communities - Peer support specialists with lived experience

Practical support resources: - Postpartum doulas - Lactation consultants - Home visiting nurse programs - Early Head Start - Women, Infants, and Children (WIC) program - Temporary Assistance for Needy Families (TANF) - Child care assistance programs - Local food banks and diaper banks - Faith-based community support - Family resource centers

Clinical Pearl:

Create a personalized resource list for each patient that includes both clinical and practical support options. Include local and online resources, crisis contacts, and specific individuals to call within your practice for urgent concerns. Review this list at each visit and update as needed. For patients with limited social support, prioritize connecting them with peer support and practical assistance programs, as these can significantly reduce stress and improve treatment outcomes. Consider keeping a regularly updated database of local resources organized by type of need for efficient referrals.

Conclusion

Perinatal mental health disorders are common, serious, and treatable conditions that significantly impact maternal wellbeing, infant development, and family functioning. By implementing evidence-based screening, assessment, and treatment approaches, psychiatric providers can play a crucial role in improving outcomes for mothers and their children.

Effective perinatal mental health care requires specialized knowledge of the unique clinical presentations, risk-benefit considerations, and collaborative care approaches relevant to this population. The perinatal period represents both a time of vulnerability and an important opportunity for intervention, with potential benefits extending across generations.

By integrating the approaches outlined in this guide into clinical practice, psychiatric nurse practitioners, physician assistants, and other mental health clinicians can provide more effective, evidence-based care for women during this critical life transition. Through early identification, appropriate treatment, and comprehensive support, we can help ensure that more women experience mental wellness during pregnancy and the postpartum period.

"When you care for a mother, you care for her child. When you care for a child, you care for the future." - Unknown

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