Abstract

Perinatal mood and anxiety disorders (PMADs) in women are commonly seen in primary care settings. However, these conditions may be under-recognized or inadequately treated due to both physician and patient factors. The purpose of this article is to help primary care providers recognize the symptoms of PMADs early, facilitate communication with patients about risks and benefits of treatment, and identify additional resources available in Northeast Florida.

Introduction

Perinatal mood and anxiety disorders can occur any time during pregnancy up to one year of postpartum. These disorders are often underdiagnosed and inadequately treated in the primary care setting. In the United States, less than 50 percent of perinatal depression is detected in routine clinical practice, with prenatal recognition rates reported at 41 percent and postnatal rates ranging from 29-43 percent. One reason PMADs are difficult to diagnose is the variation in clinical presentation which could include depression, anxiety, mania, or psychosis. In addition, perinatal depression and anxiety symptoms may go unrecognized because of overlap with the changes in sleep, appetite, energy, and libido that are common in a normal pregnancy.

Women who are suffering from PMADs are often reluctant to disclose their symptoms to their physician because of the stigma associated with mental health, or fear of hospitalization or having their children taken away. Primary care providers may find it challenging to talk with their patients about the various available treatment options due to limited data and lack of consensus about medication use in pregnancy and lactation. Primary care providers may be unaware of psychosocial resources available to help their patients. If left untreated, PMADs can pose significant health risks to both the mother and newborn. Table 1 identifies common risk factors for perinatal mood and anxiety disorders.
Screening for Perinatal Mood and Anxiety Disorders

The American College of Obstetricians and Gynecologists (ACOG), the U.S. Preventive Services Task Force (USPSTF), and the American Academy of Pediatrics (AAP) recommended universal screening of pregnant and postpartum women for depression.\textsuperscript{2,3,4} The guidelines as to when and how often to screen varies by organization. ACOG recommends routine screening for depression for all women at least once during the perinatal period with close monitoring of any woman with a high risk of depression.\textsuperscript{2} USPSTF recommends screening for depression in the general population, including pregnant and postpartum women but makes no additional comments about timing.\textsuperscript{3} AAP recommends that pediatricians screen mothers for postpartum depression at the baby’s 1, 2, 4, or 6 month visits.\textsuperscript{4} Postpartum Support International (PSI), an organization dedicated to promoting awareness, prevention, and treatment of mental health issues related to childbearing, recommends screening at the first prenatal visit, at least once in second and third trimester, and at the six week postpartum obstetrical visit. PSI also recommends repeated screenings at 6 and 12 months in OB and primary care settings and at 3, 9, and 12 months for pediatric visits.

Universal screening helps identify women at risk, removes the stigma of PMADs, and decreases the liability for medical providers. The Edinburgh Postnatal Depression Scale (EPDS) is one of the most frequently used screening tools in a primary care setting. It is a brief 10-item tool that is free, easy to administer (self-reported by the patient), and available in 23 languages. The EPDS includes anxiety symptoms which are prominent in perinatal depression and excludes constitutional symptoms which may be normal in pregnancy. A positive screen is considered to be 12 or more points or endorsing suicidal ideation on question 10. The Mood Disorder Questionnaire is commonly used in primary care settings to screen for a history of bipolar mania. A positive screen is considered 7 or more affirmative answers for manic symptoms that have occurred around the same time period and caused the patient moderate to severe impairment.

Screening alone is inadequate. It is essential that a primary care provider assists a woman who screens positive for PMADs with getting effective treatment and appropriate follow-up.

Depression

Postpartum blues occur in 50 to 85 percent of women within the first few weeks after childbirth.\textsuperscript{5} New mothers may feel overwhelmed and become highly reactive to their environment with frequent crying spells and irritability. Helpful interventions include additional rest and emotional support for the mother, usually from family and friends. Postpartum blues are most likely related to hormonal changes and disruption in sleep patterns associated with caring for the newborn. If symptoms persist, further evaluation is necessary.
Approximately 10-15 percent of women are affected by depression during or after pregnancy.\textsuperscript{6} Untreated depression during pregnancy is a strong predictor of postpartum depression after delivery. Postpartum depression most often occurs in the first three months but may occur at any time in the following year. Symptoms can emerge when mothers are attempting to wean the baby off breastfeeding or when the menstrual cycle returns. Depressed women may endorse feelings of worthlessness or guilt and express that they do not feel they are a “good enough” mother. They may doubt their ability to care for their child or provide a stable home. They may even believe that their child would be “better off without them.”

A major depressive episode lasts more than two weeks and is characterized by sad mood or loss of interest in most activities, changes in appetite, weight and sleep patterns. Often, women will report having poor concentration, fatigue, and decreased activity level. In moderate to severe depressive episodes, women may experience suicidal thoughts or behaviors. Self-harm ideation is commonly seen with PMADs but the risk for suicide attempts and deaths is lower during and after pregnancy than among women in the general population. Suicide was found to account for up to 20 percent of all postpartum deaths.\textsuperscript{7} Risk factors for suicide in pregnant women include unwanted pregnancy, inability to get a desired abortion, previous pregnancy loss or death of children, abandonment by a partner, and stopping psychotropic medications abruptly.

It is important to screen for bipolar disorder whenever a woman presents with depressive symptoms in pregnancy or postpartum. The postpartum period is a time of high risk for onset and recurrence of bipolar disorder in women. More than 70 percent of women who discontinue mood stabilizer medications during pregnancy will have a relapse before delivery.\textsuperscript{8} Antidepressants should not be prescribed if bipolar disorder is suspected as they may precipitate either mania or a mixed state with symptoms of depression and mania.

Postpartum psychosis is a rare occurrence affecting 1-2 out of 1,000 births in the general population.\textsuperscript{9} The risk is significantly increased in women with a personal or family history of bipolar disorder. Postpartum psychosis usually appears suddenly and may start within hours or days of delivery, but most cases occur within two weeks of delivery. Mothers with postpartum psychosis will often present with confusion or disorientation, labile moods, agitation, hallucinations, and delusions. These women have lost touch with reality and exhibit poor insight into their illness. This condition represents a psychiatric emergency and is associated with a five percent risk of suicide and a four percent risk of infanticide.\textsuperscript{9}

**Panic Disorder**

Studies of panic disorder during pregnancy have found conflicting results, with some reporting improvement while others report worsening of symptoms. A general consensus is that the postpartum period is most likely associated with increased risk of relapse for panic symptoms.\textsuperscript{10} Women may report feeling very anxious or nervous with an impending sense of doom, experience shortness of breath or a sensation of choking accompanied by chest pain or discomfort, or
describe palpitations often associated with tachycardia. They may experience hot flashes, numbness or tingling sensations, and be tremulous during an attack. A woman may feel like she is dying, going crazy, or losing control. There may not necessarily be an identifiable trigger with panic attacks as a person can even wake up from sleep in a state of panic. Women who fear having subsequent attacks may actively avoid exposure to real or imagined threats leading to isolation and decreased functioning.

**Generalized Anxiety Disorder**

Generalized anxiety disorder is prevalent in 8–10 percent of pregnant women and 4–10 percent in the postpartum cohort. Pregnant and postpartum women worry excessively about their own health and their baby’s health and their perceived mortality. These women also experience irritability, decreased concentration, restlessness, and insomnia and may endorse multiple somatic symptoms of headaches, non-specific aches and pains, and gastrointestinal disturbances well outside of what is expected in normal pregnancy.

**Obsessive Compulsive Disorder**

Pregnancy and childbirth can exacerbate symptoms of Obsessive Compulsive Disorder (OCD). Obsessions of contamination and washing or cleaning rituals are most common during pregnancy, while postpartum OCD tends to be manifested as distressing, intrusive thoughts of harming the infant, accompanied by avoidance behaviors or checking rituals. Unlike mothers with postpartum psychosis, mothers with perinatal OCD have good insight into their illness and usually do not want to act on these scary thought processes. In general, mothers with postpartum OCD become hypervigilant and overprotective of their children.

**Post-Traumatic Stress Disorder**

Women may experience Post-Traumatic Stress Disorder (PTSD) symptoms related to pregnancy complications and birth trauma or have a re-emergence of symptoms from past traumatic experiences such as childhood abuse. The trauma is re-experienced through flashbacks, nightmares, and intrusive thoughts often triggered by environmental cues that resemble aspects of the traumatic event often leading to avoidance of settings triggering the response. Women experiencing PTSD will describe feeling detached from their newborn and others around them. These mothers experience heightened arousal and an exaggerated startle response and hypervigilance toward perceived threats. They may present as depressed due to negative thoughts and feelings about their future.
Treatment Considerations for PMAD

When considering treatment options of PMADs, a medical provider must always weigh the risks of untreated PMAD against the risks and benefits of treatment for the mother and the baby. Table 2 summarizes the risks of untreated PMAD.

Psychoeducation

Psychoeducation is a critical component of treatment of all perinatal mood and anxiety disorders, regardless of severity of symptoms. Table 3 highlights some talking points to enhance communication between a primary care provider and a patient with symptoms of PMADs.

Psychotherapy

If a patient has access to psychotherapy and is motivated to participate, psychotherapy can be very effective for PMADs. A variety of treatment approaches are available such as cognitive behavioral therapy to help a mother recognize maladaptive thoughts and behaviors and improve her problem-solving and coping skills. Mindfulness training and relaxation techniques can facilitate reducing anxiety. Interpersonal therapy can help women address role changes, improve relationships, cope with grief, and increase their support network.

Medication Considerations

In cases where the symptoms are significantly impairing a woman’s ability to care for herself or her child, disrupting relationships, or significantly interfering with daily functioning, medication is often recommended. Women with suicidal ideation or attempts, psychosis, or bipolar disorder should be managed by psychiatry. When considering the use of a specific drug in a pregnant or breastfeeding woman, one must consider teratogenicity, neonatal toxicity and neurobehavioral outcomes of the drug. The effects of the drug should be compared to the baseline rate of 1-3 percent of major congenital malformations in U.S. born infants.

FDA Pregnancy Label Changes

In June 2015, the U.S. Food and Drug Administration (FDA) implemented a new product labeling system for medication safety in pregnancy. This new system replaced the outdated lettering system of A, B, C, D, and X. The old system did not address dosing of medications, time of exposure to the medication, and relied excessively on animal rather than human data. The new system includes sections for pregnancy, lactation, and information regarding females and males of
reproductive age. The pregnancy section includes information from pregnancy exposure registries, animal and human data, a risk summary, and clinical considerations. The lactation section includes information about breastfeeding such as the amount of the drug found in the breastmilk and its potential effects on the nursing infant. The section entitled “Females and Males of Reproductive Age” includes information about the need for pregnancy testing, contraception, and infertility as it relates to the drug.

Use of Antidepressants in Pregnancy

Selective serotonin reuptake inhibitors (SSRIs) are considered the first line of treatment for all symptoms of depression and anxiety. The one exception is with bipolar depression where the use of antidepressants may precipitate manic symptoms and worsen the overall course of the illness. Pregnant women with a history of depression need to be cautioned about prematurely discontinuing their antidepressant medication. Cohen et al showed that women who stopped their antidepressant during pregnancy were five times more likely to have a relapse of depression during pregnancy, usually by the 2nd trimester, than those who continued their antidepressant during pregnancy.12

Overall, with the exception of Paroxetine (Paxil), there does not appear to be an increased risk of major congenital malformations with exposure to antidepressants in utero, although many agents have limited data. Fluoxetine (Prozac) and Sertraline (Zoloft) are often preferred agents because they have the best safety data. Paroxetine (Paxil) exposure in the first trimester has been associated with cardiac defects and should only be used if there are no other choices for a particular patient. There is limited data on the use of Serotonin Norepinephrine Inhibitors (SNRIs), Bupropion (WELLBUTRIN), Mirtazapine (REMERON), and monoamine oxidase inhibitors in pregnancy. Tricyclic antidepressants are usually not tolerated as well as SSRIs due to orthostatic hypotension and constipation which can be worsened during pregnancy.

Use of SSRIs after the 20th week in pregnancy has been associated with Persistent pulmonary hypertension of the newborn (PPHN), a rare condition in which newborns have high blood pressure in their lungs and are not able to get enough oxygen into their bloodstream. Despite medical advances, PPHN still has a 10 percent mortality rate and is associated with significant long-term morbidities in up to 25 percent of surviving infants, including neurodevelopmental impairments and hearing difficulties.13 PPHN is also associated with maternal smoking, maternal diabetes, sepsis, meconium aspiration, and Cesarean-section. In the U.S. general population, approximately 1 to 2 babies per 1000 infants develop PPHN shortly after birth, and often require intensive medical care. In a study of SSRI exposed neonates, PPHN was six times more common than non-exposed infants.14 Subsequent studies have not supported this finding, directing the FDA to advise healthcare professionals not to alter their current clinical practice of treating depression during pregnancy.

Up to 30 percent of neonates exposed to SSRIs or SNRIs in the third trimester experience a neonatal adaptation syndrome. This syndrome is characterized by increased crying and irritability,
changes in muscle tone, tremulousness, feeding and sleep problems. It may also be associated with respiratory difficulty, seizures, and prolonged QT interval on electrocardiogram in more severe cases. These symptoms are usually mild and transient with spontaneous resolution by two weeks of age. The risk of neonatal adaptation syndrome increases with exposure to multiple agents particularly when in conjunction with benzodiazepines. Reducing the dose of the SSRI or SNRI antidepressant before delivery does not lower the risk to the neonate and may worsen the mother’s depressive condition.

**Use of Antidepressants in Breastfeeding**

SSRIs are considered safe in breastfeeding. Infants are exposed to more of the drug in utero than during lactation. Sertraline (Zoloft), paroxetine (Paxil), and fluvoxamine (Luvox) are considered the first line agents for treatment of depression and anxiety due to a low degree of excretion in breast milk. Mirtazapine is also considered safe in lactation. Fluoxetine (Prozac) has a long half-life and is more likely to accumulate in breastfed infants. There have been reports of irritability, sleep disturbance, and sedation in SSRI and SNRI exposed breastfeeding infants, but no long term negative effects on growth or neurobehavioral development. Tricyclic Antidepressants, with the exception of doxepin (Sinequan), are considered relatively safe in breastfeeding. Doxepin has a long half-life, higher infant plasma concentrations, and has been associated with respiratory depression in two case reports. Monoamine Oxidase Inhibitors (MAO-I) antidepressants are best avoided during lactation secondary to limited safety data, significant drug interactions, and dietary restrictions. There is one single case report of a seizure in a six-month old infant that was possibly related to bupropion (WELLBUTRIN) exposure in pregnancy, but multiple other case reports found no adverse events.

**Psychosocial Supports and Resources**

Primary care providers need help identifying local psychosocial supports and resources for women with PMADs. Table 4 emphasizes some of the resources available to patients in Northeast Florida.

**Conclusion**

The study and practice of treating perinatal mood and anxiety disorders is an emerging field in psychiatry. As research continues, the hope is to further understand the prevalence and impact these disorders have on women and their families. There is a need to develop more clearly defined guidelines for providers that facilitate early recognition of mood disorders in pregnant women and to offer them evidenced-based treatments. An interdisciplinary team approach of healthcare providers and community supports needs to be developed in an effort to remove stigma, increase provider knowledge, and deliver high quality patient-centered care.
### Table 1: Risk Factors for Perinatal Mood and Anxiety Disorders

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Associated Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>History of Previous Perinatal Mood and Anxiety Disorder</td>
<td>Financial Stress /Unemployment</td>
</tr>
<tr>
<td>Personal History of Mood or Anxiety Disorders not related to pregnancy</td>
<td>Recent loss/Bereavement</td>
</tr>
<tr>
<td>Family history of Mood or Anxiety Disorders</td>
<td>History of Trauma</td>
</tr>
<tr>
<td>Complications during pregnancy or labor and delivery</td>
<td>Fetal/newborn loss</td>
</tr>
<tr>
<td>Significant mood reactions related to hormonal changes (puberty, menstrual</td>
<td>Teen pregnancy</td>
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<tr>
<td>cycle, oral contraceptives)</td>
<td></td>
</tr>
<tr>
<td>Unplanned pregnancy</td>
<td>Substance abuse</td>
</tr>
<tr>
<td>Intimate Partner Violence</td>
<td>Difficulty breastfeeding</td>
</tr>
<tr>
<td>Thyroid imbalance</td>
<td>Military families</td>
</tr>
<tr>
<td>Inadequate social supports</td>
<td>Parents of Multiples</td>
</tr>
</tbody>
</table>

### Table 2: Risks of Untreated Perinatal Mood and Anxiety Disorders to Mother and Baby

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Associated Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decreased self-care of the mother</td>
<td>Higher rates of preterm birth</td>
</tr>
<tr>
<td>Noncompliance with routine prenatal care</td>
<td>Higher rates of low birth weight</td>
</tr>
<tr>
<td>Increased use of tobacco, alcohol, other substance use</td>
<td>Higher rates of pre-eclampsia</td>
</tr>
<tr>
<td>Increased impulsive and reckless behaviors</td>
<td>Higher rates of gestational diabetes</td>
</tr>
<tr>
<td>Increased risk of mother being a victim of intimate partner violence</td>
<td>Increased risk of infantile colic</td>
</tr>
<tr>
<td>Impaired maternal-infant bonding</td>
<td>Developmental delays/behavioral problems in children</td>
</tr>
</tbody>
</table>
Table 3: Talking Points About Perinatal Mood and Anxiety Disorders

- PMADs are common and treatable.
- Identify support people who can help patient emotionally and practically.
- Encourage self-care including healthy nutrition, regular physical activity, and adequate rest.
- Discuss good sleep hygiene techniques.
- Give patient permission to ask for help when she needs it from family or friends.
- Recommend short, regular breaks from childcare.
- Encourage patient to get outside and get fresh air.
- Advise mother not to read, watch, or participate in upsetting materials on TV or social media.
- Recommend complementary and alternative therapies (massage, acupuncture, yoga).
Table 4: Resources for Patients and Providers for Perinatal Mood and Anxiety Disorders

<table>
<thead>
<tr>
<th><strong>Organization</strong></th>
<th><strong>Website</strong></th>
<th><strong>Telephone</strong></th>
<th><strong>Services Provided</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>UF Health North - Mama Birds Support Group at the Nest</td>
<td>north.ufhealthjax.org</td>
<td>904-422-0953 Beth Higley</td>
<td>FREE support group offered the 1st and 3rd Fridays of each month</td>
</tr>
<tr>
<td>Women’s Center of Jacksonville</td>
<td>womenscenterofjax.org</td>
<td>904-722-3000</td>
<td>Individual &amp; group therapy, Sexual violence counseling</td>
</tr>
<tr>
<td>First Coast Women’s Services - Hope &amp; Healing Program</td>
<td>fcws.org/hope-healing</td>
<td>904-549-6114</td>
<td>Miscarriage, Stillbirth, and Early Infant loss Grief Recovery</td>
</tr>
<tr>
<td>Postpartum Support International</td>
<td>postpartum.net</td>
<td>1-800-944-4773</td>
<td>Educational materials, Online support groups for moms and dads, Chat with an expert - live phone sessions, Provider Directory &amp; Provider Training</td>
</tr>
<tr>
<td>Organization of Teratology Information Specialists</td>
<td>mothertobaby.org</td>
<td>1-866-626-6847</td>
<td>Fact sheets, Teratogen counseling, Pregnancy studies, Substance abuse and mental health treatment, Trauma services, Housing and childcare</td>
</tr>
<tr>
<td>Gateway Community Services – Pregnant and Postpartum Program</td>
<td>gatewaycommunity.com/addiction-rehabilitation-services/pregnant-postpartum/</td>
<td>1-877-389-9966</td>
<td>Patient education, Support groups, Provider directory, Peer and family support groups, Educational programs</td>
</tr>
<tr>
<td>Mental Health America of Northeast Florida</td>
<td>mhajax.org</td>
<td>904-738-8420</td>
<td>Individual, Couples and Family Counseling</td>
</tr>
<tr>
<td>National Alliance of Mentally Ill – Jacksonville</td>
<td>namijacksonville.org</td>
<td>904-724-7782</td>
<td>Life Coach Services</td>
</tr>
<tr>
<td>Jax Psychotherapy</td>
<td>Jaxpsychotherapy.com</td>
<td>904-674-8635 Angela Hainsworth, LMHC</td>
<td>Fertility counseling, Acupuncture/Chiropractic, Nutrition/fitness, 4th Trimester Fitness, <a href="http://www.4tfit.com">www.4tfit.com</a></td>
</tr>
<tr>
<td>Bay &amp; Bee Motherhood Support Group</td>
<td><a href="http://www.baynbee.com">www.baynbee.com</a></td>
<td>904-221-1900 for Jacksonville, 904-217-3637 for Bartram Springs</td>
<td>FREE support group offered every 3rd Friday at 3pm (Jacksonville)</td>
</tr>
<tr>
<td>Happy in Jax Life Coaching</td>
<td><a href="http://www.happyinjax.com">www.happyinjax.com</a></td>
<td>904-710-9007 Lisa Hosto</td>
<td>Life Coach Services</td>
</tr>
<tr>
<td>4th Trimester Fitness</td>
<td><a href="http://www.4tfit.com">www.4tfit.com</a></td>
<td>(336) 813-0223 Emily Wannenburg</td>
<td>Fitness/personal training</td>
</tr>
<tr>
<td>Postpartumjax</td>
<td>Postpartumjax.com</td>
<td>904-370-3868 Jenny Bowden, LMHC</td>
<td>Counseling services, Educational resources, Bringing Baby Home Educator, Facebook page</td>
</tr>
<tr>
<td>Mumda</td>
<td>Mumda.org</td>
<td>904-791-2933</td>
<td>Doulas, Fertility counseling, Acupuncture/Chiropractic, Nutrition/fitness</td>
</tr>
</tbody>
</table>
References


CME Post Test
Return by July 1, 2021 BY EMAIL to Kristy@dcmsonline.org

1. All of the following statements are TRUE regarding recognition of perinatal mood and anxiety disorders (PMADs) except:
   A. Perinatal depression and anxiety symptoms may go unrecognized because of overlap with the changes in sleep, appetite, energy, and libido that are common in a normal pregnancy.
   B. There are no identifiable risk factors to help identify women who may be more likely to experience PMADs.
   C. Women who are suffering from PMADs are often reluctant to disclose their symptoms to their physician because of the stigma associated with mental health, or fear of hospitalization or having their children taken away.
   D. Perinatal mood and anxiety disorders can only occur anytime during the pregnancy and up to one year after childbirth.

2. Why is universal screening of PMADs important?
   A. Universal screening identifies women at risk of PMADs
   B. Universal screening removes the stigma of PMADs
   C. Universal screening decreases the liability for medical providers
   D. All of the above statements are true.

3. All of the following statements are true about postpartum blues except:
   A. Can occur in 50-85% of women after childbirth
   B. Characterized by tearfulness, feeling overwhelmed, irritability, and high emotional reactivity
   C. Requires urgent referral to a mental health provider or hospital admission
   D. Most likely related to hormonal changes and sleep disruption

4. Which of the following statements about the EPDS (Edinburgh Postnatal Depression Scale) is true?
   A. It is used to screen for depression and anxiety in pregnancy and postpartum.
   B. It has to be completed by a medical provider and takes more than 20 minutes to complete.
   C. It is only available in English and Spanish languages.
   D. A positive screen does not require any further action by the healthcare provider.
5. All of the following statements are true regarding use of psychotropic medications during breastfeeding except:

A. Breastfeeding is contraindicated with the use of SSRI antidepressants during pregnancy.
B. Women who stopped their antidepressant during pregnancy were five times more likely to have a relapse of depression during pregnancy than those who continued their antidepressant during pregnancy.
C. Use of SSRIs after the 20th week in pregnancy has been associated with persistent pulmonary hypertension of the newborn (PPHN).
D. Up to 30 percent of neonates exposed to SSRIs or SNRIs in the third trimester experience a neonatal adaptation syndrome.

6. Which of the following factors have been associated with increased risk of suicide in the perinatal period?

A. Postpartum psychosis
B. Previous pregnancy loss or death of a child
C. Stopping psychotropic medications abruptly
D. All of the above

7. Which of the following outcomes has not been associated with untreated PMADs?

A. Higher rates of pre-term birth and low birth weight
B. Increased use of tobacco, alcohol, and other illicit substances by the mother
C. Improved maternal-fetal bonding
D. Developmental delays and behavioral problems in offspring of depressed mothers

8. Evidence based treatment options that are effective for perinatal mood and anxiety disorders include:

A. Cognitive behavioral therapy (CBT) and interpersonal psychotherapy (IPT)
B. Psychoeducation and social support
C. Pharmacotherapy with the consideration of risks and benefits of the medications
D. All of the above
9. All of the following statements are true about bipolar disorder in pregnancy except:

A. It is important to screen for bipolar disorder whenever a woman presents with depressive symptoms in pregnancy or postpartum.
B. SSRI antidepressants are the drugs of choice in treatment of bipolar depression.
C. Bipolar disorder is associated with increased risk of postpartum psychosis.
D. More than 70 percent of women who discontinue mood stabilizer medications during pregnancy will have a relapse before delivery.

10. Which of the following mental health disorder is not included under the label of Perinatal Mental Health Disorders?

A. Generalized anxiety disorder
B. Obsessive compulsive disorder
C. Post-traumatic stress disorder
D. Attention deficit disorder

EVALUATION:

1. What will you do differently as a result of this information?
_________________________________________________________________________________
_________________________________________________________________________________

2. How will you apply what you learned to your practice?
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

Please evaluate this article. Circle one number using this scale: 1= Strongly Agree to 5= Strongly Disagree

The article met the stated objectives: 1 2 3 4 5
The article was appropriate to my practice: 1 2 3 4 5
The topic was current and well presented: 1 2 3 4 5