



Clinical Recommendations

Clinical Issues for Prepartum and Postpartum Depression

It is recommended that pre and postpartum depression be managed the same way as depression at any other time except for the additional concerns about breast feeding. ¹

Psychotherapy: ^{1,2,3}

- Individual or group therapy is recommended (along with marital therapy, in some cases)
- Therapy is often seen as preferable to the use of antidepressants by some women, because of concerns about the safety of antidepressant use during lactation (see below)
- Interpersonal therapy can be particularly effective.
- Consider marital counseling or at least couples/family education and support.
- The effects of the mother's postpartum depression on other family members should be taken into consideration.
- Interventions that work with more than one family member at a time should be considered.

Employee Assistance Program (EAP), when available:

- EAP and worklife benefits with their combination of emotional and practical support offer excellent support.
- EAP can be a resource to gather tangible services that help the family from childcare support, to financial counseling.
- EAP is an excellent place to discuss issues in the workplace, including when to return to work.
- EAP can give very real support and guidance to other family members in understanding the problem and dealing with their own concerns.

Pharmacotherapy: ^{1,2,3}

- There is no clinical indication for women treated with TCAs (other than doxepin) paroxetine, sertraline, or fluoxetine, to stop breast feeding, provided the infant is healthy and its progress monitored.
- The benefits of treatment versus infant psychotropic exposure should be explained and documented.
- Where possible, the husbands and/or significant others should be involved in the decision.
- Antidepressants should be initiated at the usual adult therapeutic dose.
- Medications prescribed to breast feeding mothers are best taken as a single dose and, if possible, should be administered before the baby's longest sleep period.
- Breast feeding is best done just before the dose and should be avoided for one to two hours after the dose where possible.
- There may be some indication that paroxetine may be preferable because of the low milk/plasma ratio. ⁴

Clinical Issues for Postpartum Psychosis: ¹

- The particular risks should be carefully assessed and the patient hospitalized if necessary.
- Special mother and baby units designed for post-partum psychosis, if available, are preferred.

- Psychosis, that occurs during childbirth or in the period immediately following childbirth, should be managed in the same way as psychotic disorders are at any other time with the additional concerns about the use of medication during breast feeding

ECT:

- In extreme cases where medications have failed, ECT should be considered, especially where there are concerns about suicide or direct risk to the infant, (e.g. failure to thrive).
5,6,7

Referring to Behavioral Health

Depending on the circumstances, you may want your patient to seek treatment from a behavioral health specialist. Patients with behavioral health coverage through CIGNA HealthCare, are not required to have a referral from a Primary Care Physician to access behavioral care services. In fact, CIGNA HealthCare members may access routine outpatient services from a participating practitioner contracted with CIGNA Behavioral Health without prior authorization and without calling CIGNA Behavioral Health.

How do I determine which providers participate in the CIGNA Behavioral Health network?

Through the CIGNA Behavioral Health website, you can search the online provider directory by provider name, zip code or specialty.

1. Go to www.CIGNABehavioral.com
2. Click “Are you in need of personal help?”
3. Click on “Find a Provider”

What if I need assistance in making a referral to a behavioral health practitioner?

You, your office staff, or the member may contact CIGNA Behavioral Health by calling Member Services at the number on the member’s CIGNA HealthCare ID card. Follow the prompts for accessing behavioral health. CIGNA Behavioral Health has trained professionals available to clarify benefit coverage, discuss options, identify appropriate participating practitioners or assist in arranging an appointment with a behavioral practitioner.

What if the member needs more urgent services?

CIGNA Behavioral Health is available 24 hours a day to assist you and your members with urgent or emergent needs. Contact CIGNA Behavioral Health by calling the Member Services number on the member’s health care identification card. The staff of CIGNA Behavioral Health can arrange emergency psychiatric evaluation or intensive behavioral services by a network provider, or authorize inpatient benefits as needed.

Any reference in this material to other organizations or companies, including their Internet Web sites, is not an endorsement or warranty of services, information or products provided by those organizations or companies.

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¹ Scottish Intercollegiate Guidelines Network. June 2002.

² Hendrick, V., Altshuler, L., Management of Major Depression During Pregnancy. *American Journal of Psychiatry* 2002; 159: 10.

³ Altshuler, L.L., Cohen, L.S., Moline, M.L., Kahn, D.A., Carpenter, D., Docherty, J.P., Treatment of depression in Women 2001. Postgraduate medicine. *The Expert Consensus Guideline Series; A Special Report*. March, 2001.

⁴ Epperson, et.al., 1997; Misri, et.al., 2000; Ohman, et.al., 1999.

⁵ Ferrill, J.J., Kehoe, W.A., Jacisin, J.J., ECT during pregnancy: physiologic and pharmacologic consideration. *Convulsive Therapy* 1992; 8: 186-200.

⁶ Yonkers, K., Wisner, K., Cohen, L., et al. Management of bipolar disorder during pregnancy and the postpartum period. Bipolar Consensus Statement. Submitted for publication.

⁷ Lentz, Sarah K., Electroconvulsive Therapy During Pregnancy, *Battleboro Retreat Psychiatry Review*, Volume 5; #1, June 1996.