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Hello and welcome to another episode of the APAOG podcast I'm the show's host and creator Morgan Bechtel. And today we'll be discussing peripartum and postpartum mood disorders. One in eight pregnant people experience some form of postpartum mood disorder, but many are hesitant to discuss their symptoms for fear of being viewed as a bad parent. Now, today, we'll discuss the pathophysiology.

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Common symptoms, complications, diagnosis and available treatment options for peripartum and postpartum mood disorders. It's my belief that by explaining these conditions and increasing awareness of their presence, we can finally end the stigma that surrounds these disorders. So listen close as we dive into the details of peripartum and postpartum.

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disorders

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Let's first start by defining what postpartum and peripartum means.

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Now the postpartum period refers to the first 12 months after birth, and peripartum means that the onset occurred during pregnancy or within the first four weeks after delivery. As mentioned in the intro, approximately 13% of women, or one in eight pregnancies, experiences postpartum depression. Postpartum depression is.

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Also considered to be the underlying cause of roughly 9% of pregnancy related deaths, there are several risk factors that increases in individuals risk of developing postpartum mood disorders and these include things like being younger than 19 during pregnancy, identifying as American Indian or Alaskan native.

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Smoking during or after pregnancy, having experienced intimate partner violence before or during pregnancy, being diagnosed with major depressive disorder or generalized anxiety disorder before during pregnancy, or having experienced neonatal or infant loss. When people hear the term postpartum depression.

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they often mistakenly think that this is referring to the baby Blues, but these are in fact 2 separate conditions with very important distinctions between them. The Blues, as a result of rapid hormonal changes, high stress.

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From birth and lifestyle adjustments and increased responsibility.

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Symptoms can include things like moodiness, crying, sadness, worry, lack of concentration and forgetfulness. The baby Blues typically develop within two to three days of delivering, and they peak over the next few days and resolve within two weeks of onset.

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Now, postpartum depression can be distinguished from baby Blues in several ways, the most important being that the symptoms last longer than two weeks and the depressive symptoms can be much more severe. Symptoms of postpartum depression include things.

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Like dysphoria or anhedonia? That feeling that you're not getting joy or enjoyment out of the things that you normally would. Other symptoms include worthlessness or excessive guilt, impaired concentration and decision making.

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Maybe even discomfort around the baby or lack of feeling towards the baby.

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And yes, sometimes even suicidal ideation and behavior. It's important to note that somatic symptoms of major depression, like changes in sleep, energy level and appetite, often overlap with the normal changes that are observed in postpartum women who are not depressed.

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Now one of the more serious symptoms of postpartum depression can be rumination about harming the baby, but this is more associated with postpartum psychosis, and we'll talk more about this later. It's important to note that the thoughts of harming the baby are generally experienced as unwanted, unacceptable, and intrusive, and they're usually not revealed unless the patient are directly questioned about it. As mentioned before, patients are often reluctant to discuss their depressive symptoms for a variety of reasons.

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One of which is this perceived social expectation that new mothers or new parents are happy and overjoyed with the birth of their child, and this can result in feelings of embarrassment and guilt and stigma when that parent doesn't necessarily feel what they think or are expected to feel.

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In addition, some parents feel that their babies will be taken away from them.

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By child welfare agencies, if they're not perceived as being the quote unquote, perfect parent, it's important to screen all new parents for postpartum depression in the weeks and months after birth. Screening is often done via the 10 item Edinburgh Post-Natal Depression Scale.

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Women may not be open to sharing these feelings.

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So it's really important to ask open-ended questions.

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That addressed patients' physical, mental and emotional well-being. If a diagnosis of postpartum mood disorder is suspected

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It's important to get a full psychiatric history, meaning previous diagnosis, medications that are tried, family history as well as labs to allow any other causes of depression like thyroid abnormalities. When diagnosing postpartum depression, a patient must meet the same diagnostic criteria as in major depressive disorder, meaning that five or more of the following symptoms.

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Have to be present during the same two-week period and represent a change from previous functioning and one of the five symptoms has to include either depressed mood or loss of interest or pleasure.

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Now the symptoms of major depressive disorder, as a refresher, include depressed mood for most of the day, nearly every day, as indicated by a subjective report. So you know, the patient says. I feel sad or empty, or hopeless, or there have been observations made by others that might suggest that the patient has been depressed, like there appear tearful other symptoms, include that the patient has markedly diminished interest or pleasure in doing all or almost all activities. Again, that's that anhedonia, significant weight loss when not eating or significant weight gain. Increased appetite can be a symptom, insomnia or hypersomnia.

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Sleeping too much or too little. Sometimes psychomotor agitation or retardation can occur, and that's again can be observed by others, not merely a subjective feeling of restlessness or being really slowed down. Having fatigue or loss of energy can be a symptom. Feeling worthless or having this excessive or inappropriate sense of guilt.

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And again, this is not merely just a sense of self-reproach or, you know, guilt about feeling sick, but just overall guilt. Other symptoms include diminished ability to think, concentrate, or indecisiveness, and more

seriously recurrent thoughts of death, not just fear of dying or those thoughts of, you know, oh, I'm driving my car. What if I just BOOP went off the road?

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These recurrent suicidal ideations without any sort of specific plan or sometimes suicide attempts with specific plans for committing suicide.

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Now these symptoms should cause clinically significant distress or impairment in social, occupational or other important areas of functioning in order to have a diagnosis of major depressive disorder or postpartum peripartum depression. The episode can't be attributed to other physiological causes or from a substance use.

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This diagnosis can also be made so long as the symptoms can't be explained by other mental disorders like schizoaffective disorders, schizophrenia, schizophreniform disorder, delusional disorder, or other psychiatric disorders. So now that we have talked about screening, talked about symptoms, we talked about diagnosis, let's talk about the treatment of perinatal and postpartum mood disorders.

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So untreated postpartum depression can resolve spontaneously, but it's really important to note that untreated postpartum depression impairs maternal functioning.

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And it's associated with poor nutritional and health outcomes for these children or offspring involved, it can interfere with breastfeeding. It can interfere with maternal infant bonding, and can have a big impact on the care of the infant and the other children, as well as the relationship between parents or other caregivers. It's also important to note that patients who recover from episodes of postpartum depression.

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Are at high risk for recurrences person approximately 40 to 50% of cases. Now the first line treatment for mild to moderate postpartum mood disorders.

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Generally is therapy their cognitive behavioral therapy, or interpersonal psychotherapy. While therapy itself is important.

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It's really important to find a therapist who has experience with postpartum mood disorders, who will really be able to connect with this patient on a, you know, this sensitive issue. Many patients have hesitations about starting medication due to fears that might harm their child either during pregnancy or during

breastfeeding. Among scientists and specialists, there's a general consensus that the benefits of antidepressants outweigh the potential risks to the infant. The risks are regarded as low.

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As an example, most SSRIs pass into the breast milk at a dose that is less than 10% of the maternal level and are generally considered compatible with breastfeeding of a healthy full-term infants.

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For breastfeeding parents, a SSRI or selective serotonin reuptake inhibitor like paroxetine or sertraline, our first line, and this is because infant serum concentrations are lower than other medications like citalopram, escitalopram and fluoxetine. However, during pregnancy, paroxetine is generally avoided as an initial treatment for pregnant patients because there have been a couple of observational studies that suggest paroxetine may be associated with a small risk of congenital cardiac anomalies. Now, evidence supporting the use of sertraline.

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citalopram or escitalopram during pregnancy include several observational studies that found that first trimester exposure to these drugs was associated.

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Little to no risk of teratogenicity.

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So during pregnancy with peripartum new disorders, we're going to recommend cetraline, citalopram or escitalopram. However, if SSRI's are not an option and that could be due to side effects, or maybe they were tried and failed in the past, the SNRI's or serotonin and norepinephrine reuptake inhibitor which are venlafaxine and desvenlafaxine appear to be safe in breastfeeding women.

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Based on observational studies of exposed infants and the lack of adverse events, if a patient is unresponsive to SSRI's and SNRI's tricyclic antidepressants, nortriptyline is usually favored due to its safety record for breastfeeding women who require benzodiazepines. Again, that's patients who are going to have really severe anxiety or agitation,

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it's generally recommended that we use very low dose of drugs that have a very short half life and no active metabolites that's going to include things like lorazepam. Now, clonazepam has no active metabolites, but it may accumulate in infants due to its long half life, so generally not considered first line, and we generally avoid diazepam.

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For lactating patients. The primary concern of using benzodiazepines in women who are lactating is the withdrawal and excess sedation in infants. So again, we try to avoid them if possible. Now, in addition to medications, there are plenty of other tools that can certainly be tried first line or

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be very, very helpful adjuncts to medication management and that's going to include things like exercise, social and peer support, and that could be from spouse or friends, you know, helping around the home, helping make meals. Or again, it could be things like the spouse or even doulas or night nurses who can help protect that mom's sleep schedule because sleep is so important after after birth and during the postpartum period. Now other things like mom classes or support groups can be helpful, but I want to emphasize that if a patient is having postpartum mood disorders, getting them in with a specific postpartum mood disorder support group is going to be super helpful because sometimes you know they join the mom groups and they hear all the other parents saying oh, things are going great and that can kind of compound the shame a little bit.

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So if you can recommend a specific. postpartum depression group. That way you have a lot of benefit for the patient now other things, parenting education classes can be helpful and you know sometimes couple in family therapy can can be helpful as well. Now to wrap up this episode, I want to quickly review postpartum psychosis. It's a very rare condition. It occurs in roughly 1 to 2 of every 1000 births and this condition is defined as a disturbance in an individual's perception of reality during the postpartum period, and the psychosis can be manifested through a couple of following symptoms. It can be delusions, which again are fixed, false idiosyncratic beliefs that are not culturally based. Hallucinations, which are these.

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Sensory experiences without any physical sensory stimulation and this can be tactile hallucinations, visual, auditory, gustatory, and even olfactory sensations.

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Other common symptoms are really disorganized thoughts as well as disorganized behaviors. Now, there's a couple of risk factors for postpartum psychosis, and this includes either a personal or family history of postpartum psychosis, a history of bipolar disorder of major depressive disorder with psychotic features in the past, and history of schizophrenia or schizoaffective disorder, and there is a subset of women who experience isolated postpartum psychosis.

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That doesn't progress to mood or psychotic episodes outside of the postpartum time period and roughly 50% of women who experience postpartum psychosis have no prior psychiatric history of psychosis. Other things that can increase the risk for postpartum psychosis is if it's a patient's first pregnancy for whatever reason, we seem to see higher rates during an initial pregnancy versus subsequent.

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Another risk factor is if a patient was on medications to help with mood, and those were stopped for pregnancy.

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There is some mixed data that says let's sleep deprivation may play a role in triggering postpartum psychosis, but there's not enough to say definitively.

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Now that we've talked about the risk factors, let's talk a little bit about the signs and symptoms of postpartum psychosis. So usually the first indication of postpartum psychosis is persistent severe insomnia, and this isn't insomnia that's related to, you know, just caring for a newborn. It is more significant and severe, and it's it's outside of those that normal.

Unfortunately, normal insomnia that comes with that other symptoms, of course, are those hallucinations and delusions we talked about earlier, and they're usually present and often associated with that disorganized thought and bizarre behavior. Now, sometimes these hallucinations can be what are called command auditory hallucinations, which is this voice inside the head instructing the parent.

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To harm the baby or themselves, and when these command to hallucinations are present, the individual or the patient requires definitely a higher level of care and likely hospitalization.

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Now, symptoms of of postpartum psychosis can also include, you know, manic symptoms or depressed mood or both. And sometimes they can have rapid mood changes. Irritability and psychomotor agitation.

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Delusions and postpartum psychosis typically do involve the baby, but they're less bizarre than are what's typically seen with schizophrenia.

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So, schizophrenic patients, they may say that their baby was ill-fated or that their baby is the devil, or that somebody might, you know, want to take their baby away. Now it's important to note that a patient's mental status may fluctuate between periods of confusion or perplexity, and then have this intermittent clearing or clarity of symptoms.

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Homicidal behavior is rare in postpartum psychosis. Approximately 1/3 of women hospitalized for postpartum psychosis experienced delusions about their infants, and about 9% of those have thoughts of harm.

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And their infants.

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Approximately 4% of women with postpartum psychosis have been found to commit infanticide.

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So how do we screen for postpartum psychosis like peripartum and postpartum mood disorders? Screening involves ruling out other causes of the symptoms, so we're going to look for other causes of psychosis, including things like substance abuse, infectious diseases like mastitis, endometritis, Cellulitis. We're going to look for things that would cause metabolic encephalopathy.

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Delirium.

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Like from eclampsia or autoimmune conditions or even drug induced psychosis, we're going to look for endocrine dysfunction again, that can be thyroid or even parathyroid diseases. And of course we're going to make sure that we're looking for central nervous system events like strokes, tumors or traumas.

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The DSM does not classify postpartum psychosis as a distinct diagnostic entity.

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Instead, patients with postpartum psychosis are assigned a diagnosis based on their primary mental disorder. With this addition specifier of peripartum onset. So, for example, you know a patient would be diagnosed with major depressive disorder with psychotic features, with peripartum onset or bipolar disorder current episode with manic Mania, with psychotic features, with peripartum onset.

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Etcetera, etcetera.

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When it comes to treating postpartum psychosis, the very first priority in all cases is that we are going to ensure the safety of the individual and their children, and this unfortunately typically involves hospitalizing these patients.

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The preferred pharmacological treatment for individuals with postpartum psychosis who do not have an established psychiatric history are typically started on antipsychotic and lithium, and the rationale behind this.

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Is that individuals with postpartum psychosis have a high likelihood of subsequent diagnosis with bipolar disorder now prior to beginning lithium, there needs to be screening for renal diseases thyroid dysfunction.

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And obtaining an EKG with any patients with coronary risk factors. So you know, diabetes, hypertension, high cholesterol, smoking, things like that, the beginning dose of lithium is 300 milligrams on the first day, then 300 milligrams twice a day beginning day 2.

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Serum lithium levels are taken five days after any medication adjustment, and of course the doses adjusted accordingly. When choosing an antipsychotic for these patients, we're generally going to prefer a second generation over a first generation and this is based on lower rates of those extrapyramidal symptoms and tardive dyskinesia.

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As a reminder, second generation antipsychotics include things like Seroquel, Zyprexa, Risperdal and Abilify treatment with second generation antipsychotics is often associated with hyperglycemia, hyperlipidemia, and weight gain. So we're going to want to keep an eye on these things.

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By getting recurrent blood work and monitoring weight.

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If a patient has a history of major depressive disorder and they present with psychosis but they're not on any antidepressants, then the preferred treatment is going to be with lithium and antipsychotic and an antidepressant. And in these cases, we're going to avoid beginning all three medications at once. We're going to start with that lithium and antipsychotic.

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Monitor for that for about a week and then at that time, if the symptoms aren't adequately treated, we're going to add an SSRI. As discussed previously, the treatment with the antipsychotic is continued for a minimum of three to six months and then that lithium monotherapy is going to be continued for up to a year in most cases, while all psychotropic medications taken by the mother.

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Are transferred into the breast milk and therefore passed on to nursing. Infant exposure to antipsychotic and antidepressant medications and breast milk appears to be low and clinically insignificant. However, there's no clear consensus on the safety of lithium in breastfeeding female.