POSTPARTUM MENTAL HEALTH

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DISCLOSURES

None

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Melinda

- 34-year old mother comes into your office for 4 week post-partum visit.
- You notice on MSE she looks fatigued, clothing is soiled, she is not smiling at the baby, very tearful in the office
- Baby is slow to gain weight
- She expresses significant guilt around not producing enough milk – stating "I knew I wasn't going to make a good mother".
- "Sometimes I feel that Johnny would be better off if I wasn't even here".

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Postpartum as a Misnomer

- Puerperium is better
- For DSM – during pregnancy or 4 weeks following delivery
- ICD – within 6 weeks
- Other definitions up to 12 months

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Common!

- Up to 16 percent of women experience postpartum depression
- 20% prepregnancy, 38% antepartum, 42% postpartum
- 54% within first month, and 40% within months 2-4

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Risk Factors

- Previous episodes of depression***
- Antenatal depression
- High levels of stress
- Young age
- Anxiety disorders
- Single marital status
- Multiparity
- Family history
- Partner violence
- Unwanted pregnancy
- Poor health
- Body image dissatisfaction
- Hx of PMDD
- Sleep disturbance
- Season of delivery (winter)
- Adverse pregnancy outcomes
- Difficult course breastfeeding

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Causes

Genetics – up to 4 fold increased risk if sibling had postpartum major depression

One study looked at family history of postpartum depression and found that 42% of people with the family history suffered, but only 15% in people without a family history

Heritability up to 40%

Hormone changes: decreased estrogen and progesterone

Increased sensitivity to hormones may predispose

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Symptoms

MSIGECAPS: mood, sleep, interest, guilt, energy, concentration, appetite, psychomotor changes, suicidal ideation

Edinburgh Depression Scale is a screening tool – not meant to be diagnostic

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Prognosis

One study showed that depression lasted at least one year in 30-50% of patients, similar to general unipolar depression

Risk of recurrence in 40-50%

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What are the Consequences?

- Breastfeeding goes down
- Impaired bonding (less reading, less peekaboo)
- Poorer health of child (not sleeping on their backs, less likely to be vaxxed)
- Impaired infant development
- Marital discord

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Suicide Risk

How do we ask about suicide?

How do we sense risk?

Leading cause of death in postnatal women, but absolute risk is low

SI in 3%, completed in 1-5/100000

Infanticide - 2-7/100,000 infants – egosyntonic vs. dystonic

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When to be Suspicious?

- Anxiety around baby's health
- Concern about mothering abilities
- Negative perception of infant
- Lack of interest in baby
- Lack of response to support or reassurance
- Using substances
- Not coming in for visits or too many visits

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When to Screen?

- EDS has improved specificity because it skips changes in sleep and appetite which are common in PP women in general
- Cut off score of 11
- Positive predictive value of 60%
- If positive, do clinical interview for diagnosis after delivery
- Some say screen, some don't – ie. ACOG says screen once 4-8 weeks after delivery, Canadian Task Force on Preventative Health Care says don't routinely screen

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DDX

- Normal postpartum changes
- Postpartum blues - mild and self-limited, resolve by two weeks
- Bipolar depression (hx of mania or hypomania, psychosis)

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Psychological Treatment

- For mild to moderate, unipolar
- Psychotherapy can be tried first
- CBT
- Behavioral Activation
- IPT
- Supportive
- Practically – CBT skills group, private 1:1 counselling
- Effective and long lasting

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Pharmacologic Treatment

- First line for severe, patient choice, or if psychological tx fails
- Antidepressant benefits largely outweigh risks
- SSRIs are first line – not associated with specific patterns of congenital anomalies
- Sertraline as the go to, citalopram or escitalopram second
- Sertraline also good in lactation
- Avoid Fluoxetine (long half life), Paroxetine (small risk of cardiac anomalies)
- Dosing: 50 mg po once daily, increase in 25-50 mg increments per week up to 200 mg

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What if it doesn't work?

- Reconfirm dx
- Optimize the dose
- If no response, change to different SSRI
- If still no response, can try SNRI (venlafaxine) – low risk, good in lactation
- Others: mirtazapine (anti-nausea effects), bupropion (weight gain, ADHD)
- rTMS, ECT

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Melinda

- You ensure low suicide risk
- Safety Plan
- Connect to clinical counsellor in the community
- Start sertraline at 50 mg and up titrate to 150 mg
- Seen every one to two weeks for check ins
- By 6 weeks, significantly improved and both mom and babe are doing well.

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What if there is psychosis?

1-2 per 1000 births

Very associated with Bipolar disorder

31% relapse rate

Ask around family hx of postpartum psychosis, history of Bipolar disorder (40% of deliveries have psychosis), schizophrenia (20%), family history of Bipolar disorder, discontinuation of psychiatric meds in pregnancy

Most common in first two weeks

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Cindy

- 25 year old female, first birth, history of recurrent depressive episodes but no mania/hypomania
- Presents to your office speaking very quickly, stating she is doing “fantastic” despite not having slept in days
- States that she was “born to procreate” and has been able to clean the closets and create art in her apartment
- States she feels she is “buzzing” with energy
- You are suspicious for hypomania, but she is very dismissive of this. Does not want medications nor referrals at this time.
- You schedule a check in for next week

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Psychosis

Persistent severe insomnia, hallucinations and delusions, command = emergency

Look for signs of mania

Could present as delirious

53% had delusions around baby (ie. “ill-fated”, “the devil”, “someone will take baby away”

Suicide rate increases – 4-11%

Infanticide 4%

Delusional thinking not the only risk – disorganization, confusion also risky

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How to ask around mania

Have you had any periods of increased energy?

What was your mood like during that time?

Did anyone else notice?

Did you need less sleep than usual?

Have you been worried about your privacy?

What about your safety? The baby’s safety?

Has anyone been talking about you?

Have you seen anything unusual?

Have you noticed any changes in your abilities?

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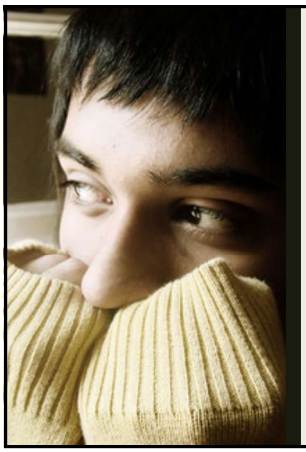

Cindy

- Next week, Cindy comes to the office looking very disheveled
- She states she believes her ex-boyfriend is spying on her and has planted cameras in the house
- She has dismantled several lights looking for devices
- She believes her baby may not be fathered by her current partner, despite her not having had any other sexual partners. She believes the baby looks like her ex-boyfriend despite not having seen him in many years.
- She is not sleeping and has heard neighbors through the walls talking about her baby.

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Treatment

- Ensure safety – certify vs voluntary, what supports are available, VGH vs RJH
- Psychiatry should be involved
- Start with an antipsychotic – Quetiapine and Olanzapine have the best evidence in breastfeeding and pregnancy
- Olanzapine 2.5 mg-5 mg to start, and can increase to 10-20 mg
- Quetiapine IR 12.5-25 mg to start, increase to 300-600 mg
- Can also use Quetiapine XR, starting dose is 50 mg
- Watch for metabolic changes
- Some will consider Lithium start
- Minimum 3-6 months, most up to 2 years

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When to use benzodiazepines?

Lorazepam over clonazepam – shorter half life, approx. 8 hrs

Sleep is medicine especially in mania/hypomania

Zopiclone also okay for breastfeeding

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Local Resources

At VGH – CL

If inpatient psychiatry needed, call PES doctor in the day, on call psychiatrist at night

On the unit: pumps, own rooms for visitation, need a family member to stay with baby

Consider request for 1:1

CBT Skills Groups

Jill Davoren, Traci McGee in the community come highly recommended for private

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Resources:

- UpToDate:
  - *Postpartum psychosis: Epidemiology, pathogenesis, clinical manifestations, course, assessment, and diagnosis.*
  - *Treatment of post-partum psychosis*
  - *Mild to moderate postpartum unipolar major depression: Treatment*
  - *Severe postpartum unipolar major depression: Choosing treatment*
  - *Postpartum unipolar major depression: General principles of treatment*
  - *Antenatal exposure to selective serotonin reuptake inhibitors (SSRIs) and serotonin-norepinephrine reuptake inhibitors (SNRIs): Neonatal outcomes*
- ACOG Guidelines
- Ottawa Review Course

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