Perinatal Depression and Psychosis

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I have no disclosures
Outline

- Intro
- Brief Case
- Defining Mood Disorders
- Post-Partum Specifics
- Breastfeeding
- Treatment Considerations
- Resources
Mood Disorders in Pregnancy: Introduction

- Up to 20% of pregnant women suffer from a mood disorder or anxiety during pregnancy

- Women with a history of psychiatric illness who discontinue medications are at higher risk of relapse
  - For example, in one study of women with depression, women who stopped treatment were 5x as likely to have a relapse of depression than those who continued

- The A, B, C, D and X category system is being phased out. It has been widely criticized as not being helpful and at times being misleading

- Instead, new system includes more comprehensive information about risks to mother and fetus and how risk may change in pregnancy
Case: Expectant mother

CC/ID: 32 yo woman with history of childhood sexual trauma, post-partum depression, pregnant with 3rd child who endorses low mood, poor concentration, decreased appetite, hypersomnia and poor motivation at 21 weeks gestation to her midwife.

HPI: Planned pregnancy. Eager for a girl and recently found out female sex. Increasingly down with poor concentration over last 3 weeks. Distrusts Western Medicine and does not like to take medication. Previous gestational diabetes and concerned this may again occur. No new stressors. Financially stable. Good relationship. 1st two children are “easy” and meeting milestones.

PMH/PSH/labs- unremarkable
Depression

Same as depression outside of the perinatal period, with specifier of “with peripartum onset”

**Major Depressive Disorder**

5 or more of the following for at least a two-week duration, represents a change in function. One of which must be either depressed mood or loss of interest. Symptoms must cause distress or impairment and not be attributable to other mental illness.

- **Depressed mood** most of the day, nearly every day
- **Decreased interest** in activities
- Weight gain or loss, or **change in eating**
- Insomnia or **hypersomnia**
- Psychomotor retardation or agitation
- Fatigue or **loss of energy**
- Feelings of worthlessness or guilt
- **Poor concentration** or indecisiveness
- Recurrent thoughts of death, recurrent SI, or SA
Bipolar Disorder

Must meet criteria for a manic episode. Manic episode may have been preceded by and/or followed by hypomania or depression (not required)

Mania

- A **distinct period** of abnormally and persistently elevated, expansive or irritable mood and abnormally and persistently increased goal directed activity or energy, **lasting at least 1 week** and present most of the day, nearly every day (and any duration if hospitalization is needed).

- During this mood disturbance 3 of the following must be present also (4 if mood is only irritable) and represent a **noticeable change from usual behavior**:
  - Inflated self esteem, grandiosity
  - **Decreased need** for sleep
  - More talkative, pressured
  - Flight of ideas, racing thoughts
  - Distractibility
  - Increased goal directed behavior or psychomotor agitation
  - Excessive high risk behaviors

- Mood disturbance causes impairment
- Episode is not due to substances, meds, etc
Post Partum Blues

- About 50-85% of women
- Appears in immediate post partum period
- Peaks on day 4 or 5
- Symptoms include mood lability, tearfulness, anxiety or irritability
- Does not interfere with ability to function
- No specific treatment required typically, however, may herald an impending mood episode in those with history

Post Partum Depression (PPD)

- 10-15% of women
- Emerges over first few months of pregnancy
- Often some depression symptoms in pregnancy
- Clinically indistinguishable from other depression
- Frequent co-morbid anxiety and OCD with intrusive thoughts
- Edinburgh Postnatal Depression scale screens for depression
Post Partum Psychosis (PPP)

- Most severe form of post partum illness
- Occurs in about 1 in 500-1000 women after childbirth
- Presentation is typically within the 48-72 hours of delivery!
- Most women with PPP develop sx within first two weeks, not always
- PPP is likely an episode of bipolar disorder, even in those with no history of mania
  - looks like manic or mixed episode
  - early signs: restlessness, irritability, insomnia
  - evolves into: rapidly shifting depression or elated mood, confusion/disorientation, erratic disorganized behavior, delusional beliefs centering around infant, auditory hallucinations which may be command
- risk of suicide or infanticide
- psychiatric emergency
Causes And Risk Factors

- Rapid changes in hormonal environment
- Hypothesis that a subgroup of women are particularly sensitive to these shifts
- Those with prior mood episodes
  - Prior PPD
  - Depression in pregnancy
  - History of depression or bipolar d/o
- Psychosocial Factors:
  - Those with marital dissatisfaction
  - Those with stressful life events
  - Those with poor social support
Post Partum Period

PPD Treatment

- Rule out medical causes with thorough history, physical and routine lab evaluation (thyroid dysfunction, anemia, etc)
- Mildest - Cognitive behavioral therapy
- Medication choice should be guided by prior response
  - First choice for PPD is typically an SSRI, like sertraline, fluoxetine or citalopram
  - SSRIs are antidepressants, anxiolytics, non-sedating and well tolerated
  - Bupropion is an acceptable alternative if SSRI is not tolerated

PPP Treatment

- Psychiatric Emergency, typically requires inpatient hospitalization
- Acute treatment with either typical or atypical antipsychotic
- Should be treated as an affective episode and treated as such
- ECT works quickly, and is considered safe
Breastfeeding

- All psychotropic medications are excreted into breast-milk. Concentrations vary widely.
- Infant’s exposure depends on dose, mother’s rate of metabolism, frequency/timing of feeding.
- Antidepressants:
  - No evidence that these cause significant risks to infant.
  - Amount of medication infant is exposed to is low.
- Bipolar illness: breastfeeding may be problematic:
  - Those with BPAD history are at high risk of relapse in the acute post partum period.
  - On demand feeding disrupts sleep, increasing risk.
  - Stopping BPAD medications is not a good plan.
  - Infants may become toxic from lithium or other mood stabilizers, as these are excreted at high levels in breast milk and infant’s metabolize differently.
  - May switch to antipsychotic, but with very careful oversight to avoid an episode.
Treatment vs Not

- Woman may present with history of illness or with new onset
- Treatment decisions need to weigh risk of treatment on mother and fetus against risk of untreated psychiatric illness in mother and impact on fetus or newborn
- Psychiatric illness in mothers causes morbidity for mother and child
- Untreated depression and anxiety in pregnancy is associated with less prenatal care, increased substance use such as alcohol and tobacco. Some studies describe low birth weight or early delivery secondary to distress.
- Untreated depression in pregnancy increases risk of post partum depression
All medications cross placenta

**Teratogenesis:** occurs when an agent interferes with in utero development

- baseline major congenital malformations in newborns is about 2-4% in the US
- organ systems developed in 1st 12 weeks after conception
- neural tube folding, closure, formation of brain and cord 0-4 weeks
- most heart and great vessels formation 4-9 weeks

**Neonatal symptoms**

- perinatal syndrome refers to neonatal withdrawal from a medication or drug exposure toward the end of pregnancy or near delivery
Pregnancy and Antidepressants

**SSRI / SNRI**

- Study of 2500 SSRI exposed infants found no increase in major malformations from baseline
- Several meta analysis of SSRI use in pregnancy showed no increased risk of major congenital malformations, with the exception of paroxetine which showed concern for septal defects
- Other studies found no association with paroxetine
- Small studies with venlafaxine found no increased risk
- Most commonly used in pregnancy: Fluoxetine, Sertraline and Citalopram

**Neonatal Distress**

- Some studies indicate that babies who are exposed to SRIs near delivery have transient increase in crying, tremor, restlessness and increased tone for 1-4 days after delivery
- Raters were not blinded to treatment status, so concern for biased rating
- Depressed and anxious mothers contributes to neonatal outcomes
- Tapering medication near delivery is not a good strategy as it raises risk of PPD and PPP
Pregnancy and Antidepressants

**SRI continued**

- *Behavioral effects*

- Exposed controls (SSRI or TCA) showed no significant differences in IQ, temperament, behavior, reactivity, mood, distractibility or activity level

- Supports the idea that SSRIs (and TCAs) are not behavioral teratogens

**TCA**

- 3 prospective studies and 10 retrospective studies examined TCA and found no statistically significant association between exposure in pregnancy and risk for major malformations

- TCAs in overdose are cardiotoxic and cause significant sodium channel blockade in overdose and for this reason, most psychiatrists use these with caution in the severely depressed

**Wellbutrin**

- 3.9% of infants had major malformations, consistent with the unexposed base risk

- A retrospective larger study that included 1200 exposed infants did not reveal increased risk
Bipolar Disorder: HX of BPAD = high risk of an episode in pregnancy and PP.

Mood Stabilizers / Anti-epileptics
- Lithium- previous high concern for Epstein’s Anomaly. Overestimated. Recent data suggests 0.05-0.1% risk in exposed
  - Monitor levels due to shifts in volume. Lithium levels drop in pregnancy, rise on delivery
- Carbamazepine- avoid- 1% risk of neural tube defects
- Divalproex sodium- avoid in all women of childbearing year. 1-6% risk of neural tube defect
- Lamotrigine- growing body that it is safer than others, about 0.9% risk of cleft palate

Antipsychotics: Approved for maintenance and acute mania treatment
- Limited data, but no studies indicate malformation risk, so may be preferred to above
- Higher potency preferred in pregnancy: haloperidol, perphenazine (trilafon)
- Atypical antipsychotics increasingly used (quetiapine, olanzapine, risperidone). Studies find no difference in malformation risk in exposed
Resources

Websites:
- MGH Center for Women’s Mental Health: https://womensmentalhealth.org

Apps:
- Lactmed
- Reprotox
- What are your favorites?
Sources


MGH Center for Women’s Health Online Reproductive Psychiatry Resourc and Information Center.


Reefhuis J, Devine O, Friedman J et al. Specific SSRIs and birth defects; Bayesian analysis to interpret new data in the context of previous reports. BMJ 2015; 350-h3190.