Peripartum Psychopathology

Kevin Junkins, MD
Shilpa Sammeta, MD

Fellows in Child and Adolescent Psychiatry
Department of Behavioral Medicine and Psychiatry
West Virginia University School of Medicine
Objectives

- Define and discuss diagnostic criteria for Peripartum Depression
- Distinguish Peripartum Depression from Baby Blues
- Learn causes and risk factors for Peripartum Depression
- Introduce screening tools for Peripartum Depression
- Understand and recognize other important psychiatric concerns in the postpartum period
- Distinguish benign thoughts of infant harm versus concerning thoughts
- Learn risk factors and protective factors for suicide
- Recognize barriers to treatment and diagnosis of maternal psychopathology
- Understand consequences of maternal psychopathology on attachment, families and child functioning
- Understand various treatment strategies for maternal psychopathology and to discuss individuals treatments’ risks, benefits and potential side effects
Peripartum Depression

Major Depressive Disorder with Peripartum Onset

Criteria and Symptoms of Major Depressive Disorder

1. Report of depressed mood from patient or others around them
2. Diminished interest or pleasure in usually enjoyable activities
3. Significant weight loss or weight gain when not trying and appetite change
4. Insomnia or hypersomnia nearly every day.
5. Psychomotor agitation or retardation
6. Fatigue or loss of energy
7. Feelings or worthlessness or guilt
8. Problems with concentration or indecisiveness
9. Recurrent thoughts of death, recurrent suicidal ideation (with or without plan)

DSM 5
Peripartum Depression

• Onset occurs during pregnancy or in 4 weeks following delivery
• 3% to 6% of patients will experience onset of a major depressive episode during pregnancy or in the weeks or months following delivery
• 50% of episodes with begin prior to delivery
• Frequently co-occur with severe anxiety and panic attacks
• Peripartum Depression has more frequent and severe anxiety than Depression at other times

DSM 5; Hendrick et al. 2000; Perfetti et al. 2004
Baby Blues

• Normal
• Occur in up to 85% of new mothers
• Important to distinguish from depression
• Few days to about a week after delivery
• Usually short lived – up to 14 days
• Symptoms
  • Emotional lability
  • More anxiety
  • Irritability
  • Fearfulness
• Not related to psychiatric history

Stein et al 1981; Hapgood 1988
Causes of Peripartum Depression

• Multifactorial in nature
• Theories include:
  • Major changes in sex hormones during pregnancy and after delivery
  • Thyroid hormone changes during pregnancy and after delivery – can even have autoimmune attacks on thyroid after delivery
  • Delivery causes adrenaline rush and high cortisol levels which cause euphoria, these changes short lived, possible contributor

Miller 2002; DSM IV 2000
Risk Factors for Peripartum Depression

• Mood and anxiety symptoms during pregnancy that causes dysfunction
• Maternal history of premenstrual dysphoric disorder
• Infants that are colicky or have difficult temperaments
• Postnatal health problems in baby or mother
• Decreased social support
• Low socio-economic status
• Shorter maternity leaves?

Probably Not Risk Factors for Peripartum Depression

- C – section
- Assisted Reproductive Technology and Methods
- Some cultures have rituals that call for seclusion and rest in mothers after delivery. Raises paternal and extended family responsibility and involvement in taking care of newborn. May be protective?

Carter et al. 2006; Ross et al. 2011; Huang and Mathers 2001; Niska et al. 1998
Diagnosis of Peripartum Depression

• Post and peripartum women should be screened for mood symptoms during pregnancy and after delivery

• Screeners are going to be persons in contact with mom and baby
  • Obstetrician
  • Pediatrician
  • Lactation consultant
  • Nurses
  • Social Workers
  • Birth to 3
  • Teachers

Campagne 2005; Marcus et al. 2001
Edinburgh Postnatal Depression Scale

• Screening postpartum women before discharge, in outpatient setting, home visits, at 6-8 week postpartum exam or whenever else there is a good opportunity
• Available in numerous languages (over 20)
• 10 questions – cutoff score is 10 – sensitivity 95%, specificity 93%
  • Score does not matter if any suicidality - refer
• Takes less than 5 minutes
• Responses scored 0, 1, 2 or 3
• Only a screening tool – not diagnostic – send for further evaluation if positive screen or any concerns
• When to give
  • Not as useful at delivery but if screened at 2-3 days postpartum more helpful
  • Especially helpful if done at that 6-8 week postpartum visit

Weissman and Olfson 1995; Cox and Holden 2003; Harris et al 1989
Edinburgh Postnatal Depression Scale

• I have been able to laugh and see the funny side of things
  0 As much as I always could
  1 Not quite so much now
  2 Definitely not so much now
  3 Not at all

• Things have been getting on top of me
  3 Yes, most of the time I have not been able to cope at all
  2 Yes, sometimes I have not been coping as well as usual
  1 No, most of the time I have coped quite well
  0 No, I have been coping as well as ever

Cox and Holden 2003
Edinburgh Postnatal Depression Scale

• I have looked forward with enjoyment to things
  0 As much as I ever did
  1 Rather less than I used to
  2 Definitely less than I used to
  3 Hardly at all

• I have felt so unhappy that I have had difficulty sleeping
  3 Yes, most of the time
  2 Yes, sometimes
  1 Not very often
  0 No, not at all
Edinburgh Postnatal Depression Scale

• I have blamed myself unnecessarily when things went wrong
  0 No not at all
  1 Hardly ever
  2 Yes, sometimes
  3 Yes, very often

• I have felt sad and miserable
  3 Yes, most of the time
  2 Yes, quite often
  1 Not very often
  0 No, not at all

Cox and Holden 2003
Edinburgh Postnatal Depression Scale

• I have been anxious or worried for no good reason
  3 Yes, quite a lot
  2 Yes, sometimes
  1 No, not much
  0 No, not at all

• I have been so unhappy that I have been crying
  3 Yes, most of the time
  2 Yes, quite often
  1 Only occasionally
  0 No, never

Cox and Holden 2003
Edinburgh Postnatal Depression Scale

• I felt scared or panicky for no very good reason
  3 Yes, quite a lot
  2 Yes, sometimes
  1 No, not much
  0 No, not at all

• The thought of harming myself has occurred to me
  3 Yes, quite often
  2 Sometimes
  1 Hardly
  0 Never

Cox and Holden 2003
Other Important Psychiatric Concerns in Peripartum

- Psychosis
- Mania
- Obsessive Compulsive Disorder
- Infanticide

Patients may stop or reduce the dose of psychiatric medications for mood stabilization or psychosis secondary to risk of fetal harm or birth defects
Peripartum 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

- Inflated self esteem, grandiose
- Little or no need for sleep but adequate energy
- More talkative or speech pressured
- Racing thoughts/Flight of ideas
- Easily and abnormally distractible
- Increase in goal directed behavior or agitated psychomotor movements
- Increase in risky behaviors

DSM 5, 2013
Peripartum Mania

A psychiatric emergency

• Poor to no insight – patient will very likely feel that things are going well

• Patient needs assessment by psychiatrist and likely inpatient admission
Peripartum Psychosis

A psychiatric emergency

• Hallucinations, delusions, perceptions of thought content
  • Hearing voices
  • Being commanded to do things
  • Seeing things other people can’t

• Decreased insight
Peripartum Psychosis

- Major Depressive and manic episodes with psychotic features occur in 1 in 500 to 1 in 1000 births
- Psychosis more likely multiparous women
- Psychosis more likely for patients with prior mood episodes, family history of bipolar disorder, personal history of depressive or bipolar disorder
- If prior postpartum episode with psychosis, risk of recurrence at each subsequent delivery is 30% to 50%
Postpartum OCD

• Several studies have reported perinatal period associated with increased incidence of new onset OCD symptoms and exacerbation of previous OCD.

• Most predominant postpartum obsession is contamination.

• Second most predominant is intense aggressive obsessions:
  • Drowning baby
  • Stabbing baby
  • Throwing down stairs
  • Putting baby in microwave
  • Sexually abusing baby

Williams and Koran 1997; Labad et al, 2005; Wenzel et al, 2005;
Postpartum OCD

• Avoidant personality disorder and obsessive compulsive personality disorder are risk factors
• Prevalence estimated at 2.6% of postpartum women at 8 weeks
• Leads to patterns of avoiding infant

Wenzel et al, 2005; Labad et al, 2005; Fairbrother and Abramowitz, 2007
Thoughts of Harming Your Baby?

• Important to ask
• Common
• Very rare that parents actually harm baby
• NOT indicative of psychosis
• Make moms feel like “bad mothers”
  • Guilt, Shame
  • Fear of discussing
• Although common, may be a symptom or indicator of Depression, OCD or Psychosis

The Postpartum Stress Center, 2010
Infanticide

• **RARE**, But Important to Screen For

5 loose categories:

1. Within 24 hours – unwanted pregnancy, denial, attempt to hide pregnancy
2. In conjunction with violent male partner
3. Infants who die because of neglect
4. Discipline gone awry
5. Purposeful – may or may not be due to mental illness

• **Infanticide more likely when postpartum psychosis occurs**

DSM 5, 2013; Meyer et al 2001
Suicide

• Important to ask - asking about suicide will not cause suicide
• There are several screening tests – from clinician administered to patient administered
• Ask about
  • Current suicidal thoughts, plans or attempts
  • Current or previous intentional self injury – whether intent was to die or not
  • Hopelessness
  • Substance use
  • Current stressors
  • Upcoming stressors

APA Practice Guidelines, July 2015
Suicide

• What happens if things get worse?
• Access to lethal means?
• Motivations for suicide?
• Reasons to live?
• History of suicidal behavior in self and biological relatives?
• Have you ever known anybody that committed suicide?
  • What did you think or feel?
Suicide Risk Factors

- Family History of Suicide
- Previous attempt
- Mental Illness
- Hopelessness
- Substance or Alcohol Use
- Impulsive or Aggressive
- Cultural or Religious Condoning
- Local Epidemics of Suicide
- Isolation
- Loss
  - Relationship
  - Social
  - Job
  - Money
- Physical Illness
- Access to Lethal Means
- Unwilling to Get Help

CDC, 2015
Suicide Protective Factors

- Access to Interventions
- Social Support, Family Support, Community Support
- Adequate Coping Skills
- Access and Willingness to Seek Help
- Effective Help and Treatment
- Cultural or Religious Beliefs that Discourage Suicide
Barriers to Diagnosis and Treatment of Peripartum Psychiatric Disorders

• Stigma of mental health issues
• Shame
• Fear of having baby taken away
• Fear of CPS involvement
• Fear of being judged or seen as unfit
• Embarrassment
• Lack of insight into seriousness of own depression
Maternal Psychopathology and Attachment

• Mothers with depression, in general, have more insecure attachments
  • Not absolute though
  • Moms can still provide warmth and comfort even if depressed
  • Infant resiliency
  • Other care givers

• As discussed earlier, several factors can hinder attachment
• Vicious cycle, irritable, non engaging baby may worsen mom’s depression

Perfetti et al 2004; Murray and Cooper 1997; Cohn et al 1990
Maternal Psychopathology and Attachment

• Maternal depression compromises the dyad’s capacity to mutually regulate the interaction, through two interactive patterns, intrusiveness or withdrawal.

• Depressed mothers are less likely to offer contingent stimulation to their infants and this disrupts their performance on nonsocial learning tasks.

• Negative affect – decreased learning

• Parenting of depressed mothers has been described hostile/punitive or withdrawn (maladaptive)

• Negative appraisals of child’s behavior

• Less confident in parental efficacy

Maternal Psychopathology and Attachment

- Early effect on developmental organization – negative representation of self and caregiver
- The consequences on the child of maternal postpartum depression are not restricted to infancy, but can extend into toddlerhood, preschool age and even school age.

Impairment in child function

• Maternal depression in the postnatal period has been associated with wide-ranging and persistent impairments in child functioning

• Studies have alluded to the poorer growth and malnourishment in infants and maternal depression has been identified as an important marker for a high risk infant group

Maternal depression and child development. *Paediatrics & Child Health*. 2004
| Table 1: Consequences of Maternal Depression |

<table>
<thead>
<tr>
<th>Stage</th>
<th>Consequences</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prenatal</strong></td>
<td>Inadequate prenatal care, poor nutrition, higher preterm birth, low birth weight, pre-eclampsia and spontaneous abortion</td>
</tr>
<tr>
<td><strong>Infant</strong></td>
<td>Anger and protective style of coping, passivity, withdrawal, self-regulatory behaviour, and dysregulated attention and arousal</td>
</tr>
<tr>
<td><strong>Cognitive</strong></td>
<td>Lower cognitive performance</td>
</tr>
<tr>
<td><strong>Toddler</strong></td>
<td>Passive noncompliance, less mature expression of autonomy, internalizing and externalizing problems, and lower interaction</td>
</tr>
<tr>
<td><strong>Cognitive</strong></td>
<td>Less creative play and lower cognitive performance</td>
</tr>
<tr>
<td><strong>School age</strong></td>
<td>Impaired adaptive functioning, internalizing and externalizing problems, affective disorders, anxiety disorders and conduct disorders</td>
</tr>
<tr>
<td><strong>Academic</strong></td>
<td>Attention deficit/hyperactivity disorder and lower IQ scores</td>
</tr>
</tbody>
</table>
Protective factors for Child

- Resiliency
- High IQ
- Low perceived maternal psychological control
- Positive relationship with healthy parent
- Helping the child to understand the parent psychopathology
- Laying stress on the lack of blame on the child’s part

Pargas RCM, Brennan PA, Hammen C, Le Brocque R. Resilience to Maternal Depression in Young Adulthood. Developmental Psychology. 2010
Role of Father Figure in Maternal Psychopathology

• Interaction with non-depressed fathers who could ‘buffer’ the effects of the mother’s depression.

• Paternal ability and availability to provide social support can promote child development

• Paternal relationship and attachment predicts long-term behavioral outcomes

• Lower Social and emotional functioning when father also has psychiatric problems

• More research required

Treatment of Maternal Psychopathology

- **Psychosocial**: 
  - Psycho-education
  - Social support
  - Interaction coaching techniques
  - Home visiting interventions (aim to improve infant’s secure attachment and psychomotor development)
  - Comprehensive social/educational/vocational rehabilitation program (working model)
Treatment of Maternal Psychopathology

• **Family Therapy:**
  - Family centered intervention
  - Linking cognitive material to life experiences
  - Developing resilience
  - Communicating about the illness
  - Improving overall Family Communication

Treatment of Maternal Psychopathology

• **Psychotherapy**
  - Psychodynamic interpersonal
  - interaction guided therapy
  - Cognitive behavioral therapy
  - Interpersonal therapy

Treatment of Maternal Psychopathology

• **Pharmacotherapy:**
  - Risk versus Benefit
  - Should be considered in moderate to severe depression and lack of response to non-pharmacological therapy
  - May be necessary in mania or psychosis when acute stabilization needed
  - Individualized decision that requires much discussion of risks, side effects and potential benefits
Pharmacotherapy

- Selective Serotonin reuptake inhibitors in pregnancy:
  - Sertraline (Zoloft)
  - Fluoxetine (Prozac)
  - Citalopram (Celexa)

- Tricyclic antidepressants like Amitriptyline, Amoxapine, Clomipramine

- Cross fetal blood brain barrier during pregnancy

- Monotherapy is preferable

- Lowest effective dose should be considered

- Medication should be continued in the postnatal period

Maternal depression and child development. Paediatrics & Child Health. 2004;
Potential Adverse Effects in Infants

• Potential Teratogenicity (<1 % risk)
• Cardiac malformations
• Preterm birth
• Low birth weight
• Spontaneous abortion
• Post partum hemorrhage
• Autism?
• Evidence of adverse effects from “observational studies”
Potential Adverse Effects in Infants

• Hypertensive disorders in pregnancy like pre-eclampsia
• Postnatal effects such as neonatal behavioral syndrome, neurodevelopmental, persistent pulmonary hypertension have been recognized in infants of mothers treated with medications
• Not associated with elevated risk of perinatal death
• Studies reported withdrawal symptoms in infants
  - Tremors
  - Gastrointestinal side effects
  - high pitched crying, muscle tensing
  - Sleep problems

Antidepressants in Lactation

• Least excreted in breast milk – Sertraline (Zoloft), Paroxetine (Paxil)
• Less exposure than in utero
• Infant exposure in dose related
• Exposure can be reduced by emptying the breasts of milk and discarding it (‘pump and dump’) approximately 8 h to 9 h after the mother has taken the medication.

How do we select the treatment?

• Prior response to treatment
• Experience of adverse effects with an agent
• Review adverse effects on breast feeding
• Concurrent interaction with other medications
Conclusions

• Peripartum Psychopathology is a risk factor for subsequent problems with attachment, family dysfunction, child psychopathology

• Baby Blues commonly occur in most post partum mothers. It is important to distinguish normal from pathological. Maternal Depression is longer lasting and more severe.

• Causes of Maternal Depression are multifactorial

• The Edinburgh Depression scale is a quick, easily accessible and reliable screening method for Peripartum Depression

• It is important that persons in contact with family are screening and being vigilant for maternal and family psychopathology
Conclusions

• Suicidal thoughts or intent, mania and psychosis are psychiatric emergencies and require immediate evaluation by a mental health professional.

• Thoughts of harming ones child are stressful but common and are not necessarily indicative of psychopathology. Careful history is necessary to determine risk to baby and mother.

• There are many barriers to seeking help for psychiatric problems. It is important to recognize and be aware of potential barriers.

• The infant of a depressed mother is at risk for developing insecure attachment, negative affect and dysregulated attention and arousal. There is an increased risk of future problems and psychopathology.

• There are many different treatment modalities for maternal psychopathology depending on severity and type. Therapy and emotional support may have less risk than medications.

• Decisions about treatment require in depth discussion and consideration or risks, benefits and potential side effects.
References


• CDC. http://www.cdc.gov/violenceprevention/suicide/riskprotectivefactors.html


References

• Cohn JF, Campbell SB, Matias R, Hopkins J. Face-to-face interactions of postpartum depressed and nondepressed mother-infant pairs at two months. Dev Psychol. 1990;26(1):15-23


References


• The Postpartum Stress Center. Are You Having Thoughts that Are Scaring You? 2010.

