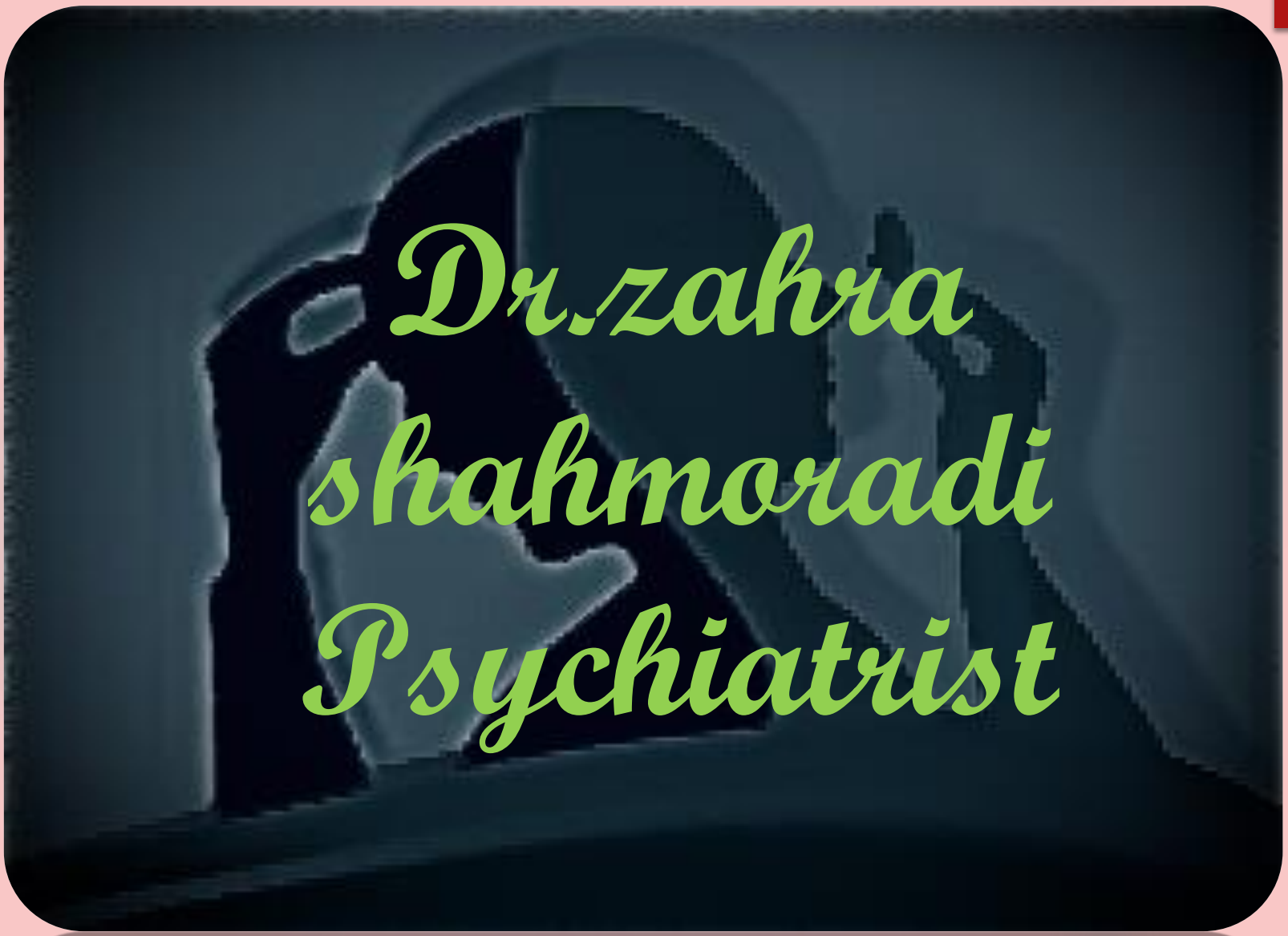

دانشگاه علوم پزشکی و خدمات بهداشتی درمانی اراک


Dr.zahra
shahmoradi
Psychiatrist

- Postpartum blue
- Postpartum depression
- Postpartum psychosis
- Maternal suicide
- Neonatal homicide

- Mild depression
- Self limited
- Risk factors of major depression or severe syndrome

P.P.blue

Etiology

- Postpartum depression
- Premenstrual mood changes
- Oral contraceptives use that is associated with mood change
- Depression syndrome predating pregnancy

40%

With in a week of delivery

P.P.blue

Etiology

p.p.blue

- Antepartum depression
- C/S
- Not breastfeeding
- Stress around child care
- Psychosocial impairment
- Family history depression

Pathogenesis

Hormonal changes → Neurotransmitter → Level activity

P.P.blue

- Decrease estrogen
- increase monoamino oxidase A(43%)
- Metabolizes :Dopamine, NEP,serotonin
- Dysphoria
- Increase MAO-A in prefrontal and ant.cingularte cortex
- In person sad crying

P.P.blue

Maternity blue

Baby blue

P.P.blue

Transient condition

P.P.blue

Sadness
Crying
Irritability
Anxiety
Insomnia
Exhaustion
Concentration
Lability

2-3day

Several mild depression symptoms

2week

Common

P.P.blue

Remit spontaneouslv

Non pathological

Risk of postpartum MDD (4-11)

Postpartum anxiety disorder

P.P.blue

There is no standardized definition for diagnostic 3-4symptom of depression

ICD10

Postpartum depression NOS

P.P.blue

DSM-5

Adjustment disorder with depressive mood

Unspecified depressive disorder

P.P.blue

P.D

Postpartum MDD

Insomnia
Dysphoria
Concentration
Fatigue

Self limited
Resolved in 2w

5symptoms=<

Somatic symptoms in P.P blue:changes in sleep and energy overlap NL W.oP.P blue

P.P.BLUE

Clinicians can determine problems with sleep and energy are due to postpartum blues or to normal puerperal-related changes by evaluating these symptoms in the context of normal expectations for the puerperium. As an example, although postpartum insomnia is common, patients who are unable to sleep even when their babies sleep may have postpartum blues.

Management

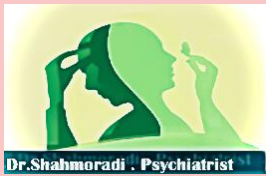
P.P.blue

- Spontaneously resolved
- Doesn't require treatment
- Reassurance
- Support
- Adequate time for sleep and rest

Pharmacotherapy

Psychotherapy

Persistent insomnia
Symptoms persist(2w)
Suicidal idea



Postpartum unipolar depression

Dr.Shahmoradi . Psychiatrist

12m.After birth

9%

Prevalence 12M

P.P.up. dep

DSM-5

occur prior to or after parturition

ICD10

onset of the episode within six weeks of delivery

DSM-5 specifier “with peripartum onset” is used when onset of major depression occurs either during pregnancy or in the four weeks follo delivery.

In women with postpartum depression that begins after delivery, onset appears to occur most often within the first few months of parturition

P.P.up.dep

Month 1
54%

Month 2-4
40%

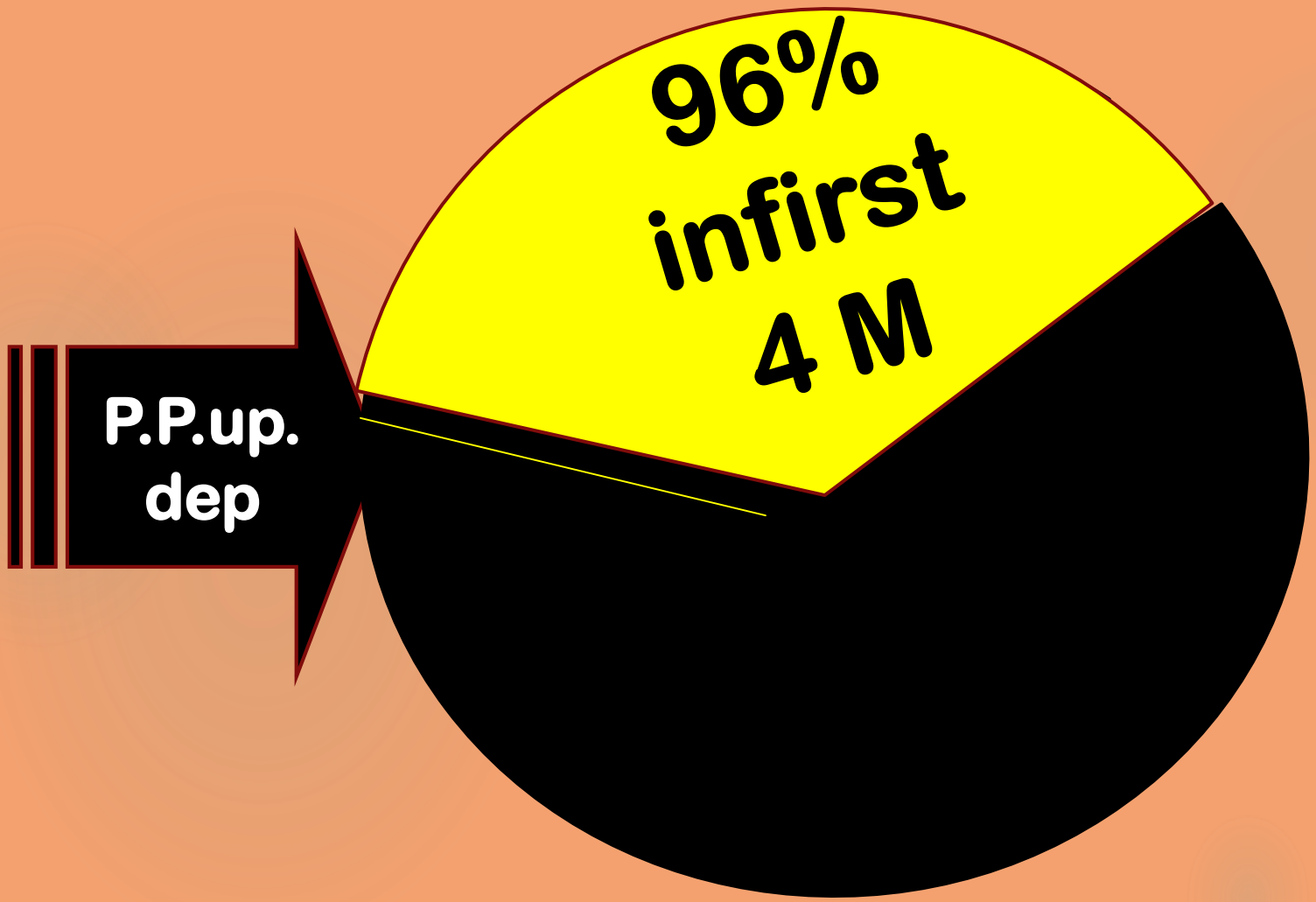
Month 5-12
6%

P.P.up.de
p

95% in 4 months
after delivery

- hospitalization for postpartum depression occurred roughly three times more often during the first five postnatal months, compared with the last seven postnatal months

P.P.up. dep



Hospitalization

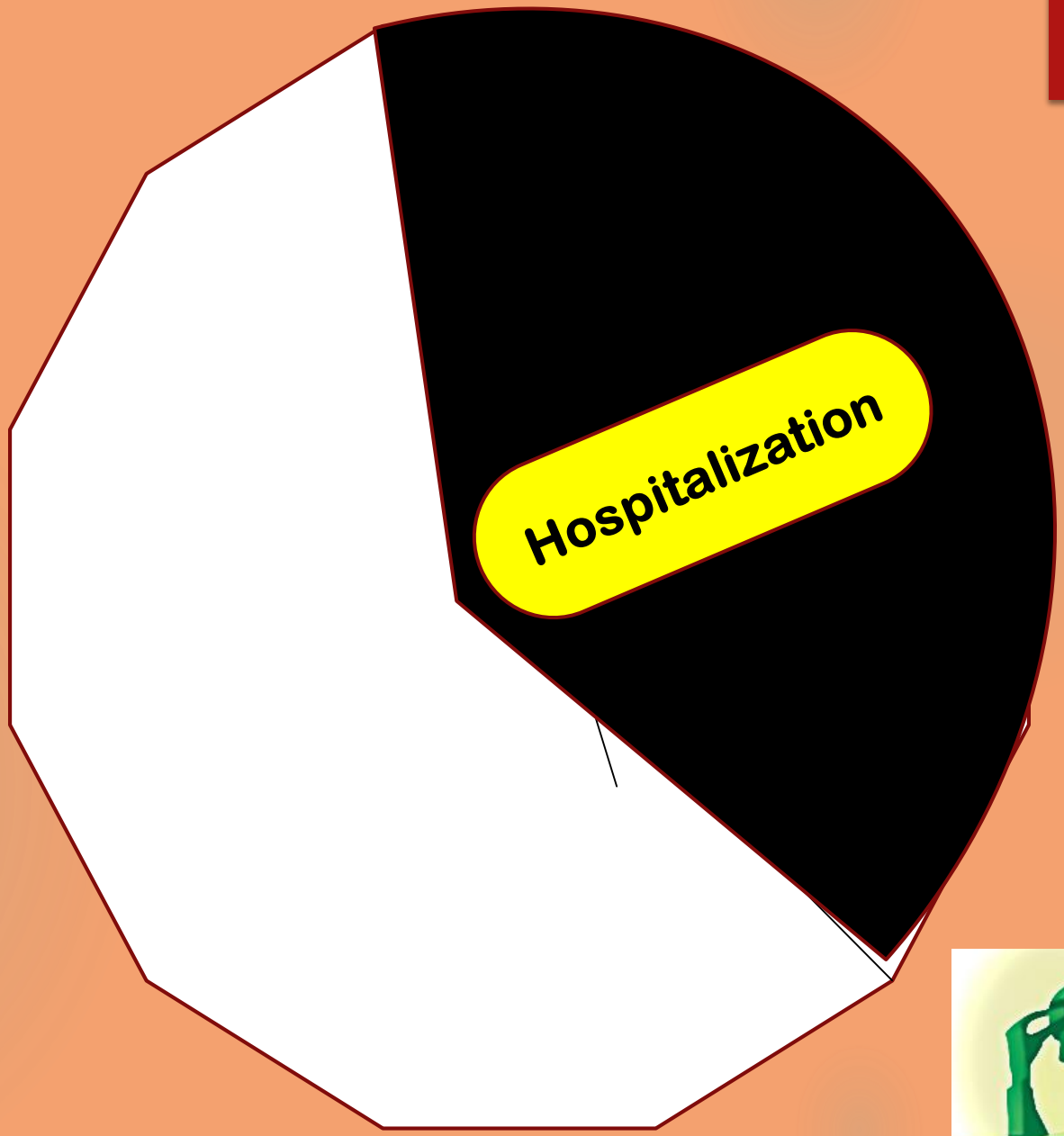
5 month

7 month

P.P.up.dep

3 times

P.P.up. dep



Previous depression

Risk factors

Antenatal depression

P.P.up.dep

High level stress postnatal

past history of perinatal or non perinatal depression

Event

Support

<25y

P.P.up.dep

Risk factors

Unwanted pregnancy
Negative attitude
Fear of child birth

Single

Physical and sexual abuse

Family history

Violence inPartner

Multipariety

Poor perinatal physical health

Risk factors

P.P.up.dep

Obesity

Gestational diabetic

Hyper tension

Infection

Personality traits

Risk factors

Neuroticism
Enduring and tendece to worry and feel anxious angry sad guilty

P.P.up.dep

PMMD

Anxiety

Insomnia

Child care stress

Adverse pregnancy and neonatal

Season

Postpartum unipolar. depression

Breast feeding difficulty

Postpartum blue

Etiology

Genetic

- One sibling had an episode P.P MDD risk of an episode in the other 4fold
- Women with FH P.P.MDD:42%
- One with no FH:15%

P.P.up.dep

Etiology

- **Hormonal**
  - **Decrease estrogen and progesterone**
  - **unusually sensitive to abrupt decreases in gonadal steroids.**

P.P.up.dep

Etiology

monoamine oxidase-A in the prefrontal and anterior cingulate cortex was elevated in women with postpartum depression

P.P.up.dep

Etiology

P.P.up.dep

neurotrophic factor were lower in women who subsequently screened positive for depression three months postpartum

DSM5

P.P.up.dep

5or more(2w)
Function
impairment
1)depressed mood
or
2)loss of interest
or pleasure

DSM5

P.P.up.dep

3)not include symptoms that are clearly attributable to another medical condition.

DSM5

P.P.up.dep

1) Depressed mood most of the day, nearly every day, as indicated by either subjective report (feels sad, empty, hopeless) or observations made by others (appears tearful).

DSM5

P.P.up.dep

- 2) Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation).

- 3) Significant weight loss when not dieting or weight gain (a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day.

DSM5

P.P.up.dep

- 4) Insomnia or hypersomnia nearly every day.

DSM5

- 5) Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).

P.P.up.dep

DSM5

P.P.up.dep

- 6) Fatigue or loss of energy nearly every day.

DSM5

P.P.up.dep

- 7) Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).

DSM5

P.P.up.dep

- 8) Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by their subjective account or as observed by others).

DSM5

P.P.up.dep

- 9) Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

DSM5

- **B. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.**

P.P.up.dep

DSM5

P.P.up.dep

- C. The episode is not attributable to the direct physiological effects of a substance or to another medical condition

DSM5

- D. The occurrence of the major depressive episode is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified and unspecified schizophrenia spectrum and other psychotic disorders.

P.P.up.dep

DSM5

P.P.up.dep

- **E. There has never been a manic or hypomanic episode.**

DSM5

P.P.up.dep

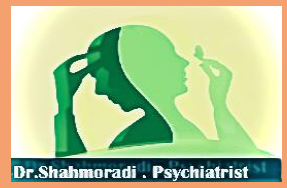
- With anxious distress
- With mixed features
- With melancholic features
- With atypical features
- With psychotic features
- With catatonia
- **With peripartum onset**
- With seasonal pattern

Substance Use
Eating Disorder
OCD
PTSD

Comorbidity

P.P.up.dep

66%
GAD



Course

resolve spontaneously or with treatment

P.P.up.dep

episodes of postpartum major depression last at least one year in 30 to 50 percent of patients

Course

develop into a persistent (chronic) depressive

P.P.up.dep

recurrence of postpartum and/or non-postpartum depression occurs in approximately 40 to 50 percent

NOT

Suicide

Obvious impairment function

Psychosis

Catatonia

P.P.up.dep

Psychotherapy (CBT) IPT +_ Pharmacotherapy

Mild-moderate

5 or 6 Criteria

Out paitiont Partial hospitalization

Poor judgment
Suicide
Functional improvement

- psychot features and catatonic have a history of severe or recurrent

Severe

7-9 Criteria

P.P.up.dep

Hospitalization

Onset of depressive symptoms during pregnan

Severity

Average score of 20 on the Edinburgh Postnatal Depression

P.P.up.dep

anxiety and suicidal

Obstetric complication(fetal stress, postpartum hemorrhage, and low birth weight)

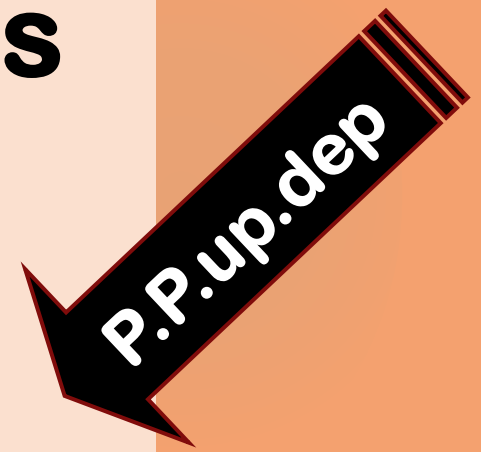
The primary treatments are psychotherapy (CBT, or IPT). However, many patients receive antidepressant medications.

P.P.up.dep

Continuation treatment is generally indicated for patients who respond to acute treatment of unipolar major depression, and additional maintenance treatment is indicated for patients with an increased risk of recurrence.

P.P.up.dep

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



.P.up.dep

Psychotherapy
ECT

P.P.up.dep

For postpartum patients who were treated with antidepressants during pregnancy up until delivery and are maintained on their medication, we continue to prescribe the same dose that was prescribed before delivery

Patients are monitored for adverse effects that may occur due to increased serum drug concentrations after delivery. Medication levels can rise because of postpartum pharmacokinetic changes that stem from decreased plasma volume and decreased hepatic enzyme activity.

P.P.up.dep

P.P.up.dep

For patients who initiate pharmacotherapy after delivery, drug doses are similar to those used in the general population of patients with depression

P.P.up.dep

Monotherapy at higher doses is preferred over medication combinations at lower doses

- Exercise
- Social/peersupport doulas or night-nurses to protect maternal sleep
- Parenting education
- Couples/family therapy

P.P.up.dep

Non response

Verify that the patient has unipolar major depression rather than a different condition such as bipolar major depression.

nonadherence is common

Non response

significant life stressors (nonsupportive partner)

comorbid psychopathology (anxiety disorder, personality disorder, or substance use disorder)

P.P.up.dep

impairs maternal functioning, is associated with poor nutrition and health in the offspring

increased risk of not breast feeding

P.P.up.dep

breastfeeding, maternal-infant bonding, care of the infant and other children, and the woman's relationship with her partner.

abnormal development, cognitive impairment, and psychopathology in the children

poorer health care of children

P.P.up.dep

Infant sleep

Child vaccinations

P.P.up.dep

Cognitive impairment and psychopathology in the child

Abnormal infant and child development

Maternal postpartum depression

interfere with maternal-infant bonding

P.P.up.dep

less likely to tell their child stories every day, and depressed mothers were also less likely to play

depressed mothers read to their children less frequently

Assessment

P.P.up.dep

Postnatal depression may be present in women who manifest the following symptoms

Anxiety about the health of the infant

up.dep

Concern about one's ability to care for the infant

Negative perception of infant temperament and behavior

Despondency for at least two weeks

P.P.up.dep

Lack of interest in the infant's activities

Lack of response to support and reassurance

Using alcohol, illicit drugs, or tobacco

Nonadherence to postnatal care

Frequent nonroutine visits with or telephone calls to the obstetrician or pediatrician

We suggest that primary care clinicians (including obstetricians, gynecologists, or pediatricians) screen all postpartum women for depression, and that screening be implemented with services in place to ensure follow-up for diagnosis and treatment.

ask :

- about their attitude toward the pregnancy and infant, functioning (ability to care for the infant)
- alcohol and drug abuse, and stressors and supports, as well as intimate partner violence

focus upon the five mood and cogniti ve sympto ms

1. Dysphoria
2. Anhedonia
3. Worthlessness or excessive guilt
4. Impaired concentration and decision making
5. Suicidal ideation and behavior

The somatic symptoms of major depression – changes in sleep, energy level, and appetite – overlap with changes observed in postpartum women who are not depressed

symptoms of depression overlap with some of the usual discomforts of the acute puerperium

low libido

difficulty sleeping

poor appetite

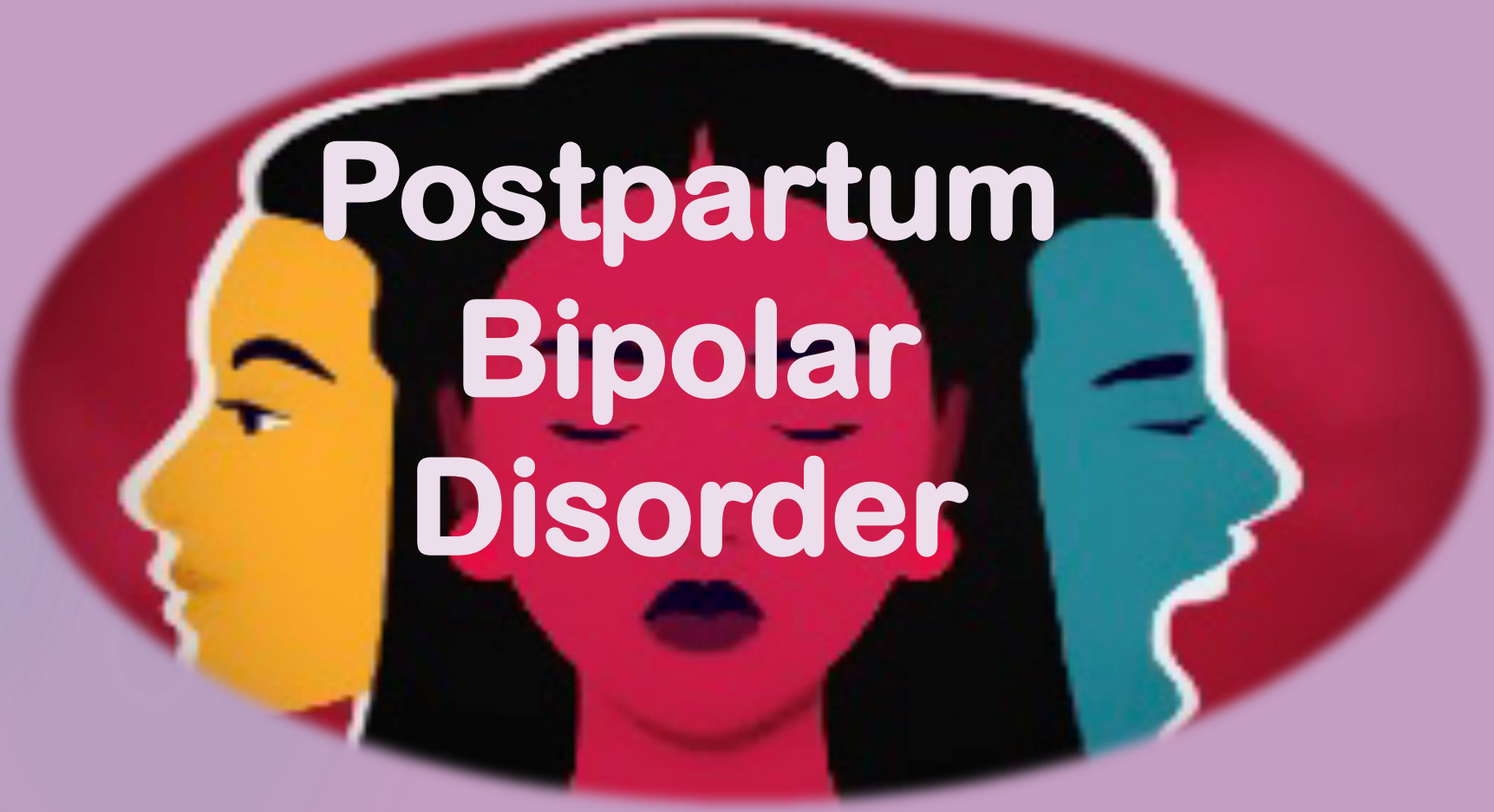
fatigue

lack of energy to the point that patients cannot get out of bed for hours is abnormal and should be distinguished from the normal lack of energy that results from sleep deprivation and caring for an infant.

Although postpartum insomnia is common, patients who are unable to sleep even when their babies sleep may have postpartum depression

Decreased appetite that is accompanied by the inability to enjoy the taste of food, having to force oneself to eat, and rapid weight loss probably represents a depressive syndrome.

Postpartum Bipolar Disorder



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DSM-5

P.P.BMD

defines the postpartum period as the first four weeks following childbirth

onset of the episode within six weeks of delivery

ICD-10

Postpartum bipolar mood episodes are referred to as “postpartum psychosis” or “puerperal psychosis,” although neither term is a formal diagnosis in DSM-5 or ICD-10

P.P.BMD

recurrence occurred significantly more postpartum patients than nongravid

risk of acute bipolar mood episode greater in the puerperium than at other times.

P.P.BMD

Onset of postpartum bipolar mood episodes occurs within a limited time period following birth of a live child. However, there is no established cutoff that separates postpartum-onset mood episodes from subsequent nonpostpartum episodes

Risk factors

P.P.BMD

- Lack of maintenance pharmacotherapy preceding or following delivery
- Prenatalmoodsymptoms and episodes
- Younger age at delivery
- Unplanned pregnancy

Risk factors

- Primiparity
- History of previous postpartum mood episodes
- Family history of mood disorder or postpartum psychosis

P.P.BMD

P.P.BMD

Onset of the first lifetime bipolar mood episode may occur during the puerperium

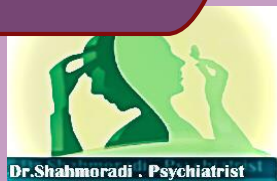
Etiology

genetic effects

P.P.BMD

decreased or erratic sleep, increased stress associated with caring for the newborn, and social issues

decreases in estrogen and progesterone



P.P.BMD

genome-wide linkage study found an area on chromosome 16

postpartum relapse occurred in significantly more patients with a positive family history of postpartum mania or psychosis

Bipolar disorder is characterized by episodes of major depression mania and hypomania

A retrospective study of 1120 pregnancies in bipolar patients found the following rates of postpartum mood episodes

P.P.BMD

Major depression – 25 %
- Mixed4%
- Mania 3%
- Hypomania 2%

P.P.BMD

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

DSM-5 diagnostic criteria for manic episode

P.P.BMD

- **B. During the period of mood disturbance and increased energy or activity, 3 (or more) of the following symptoms (4 if the mood is only irritable) are present to a significant degree and represent a noticeable change from usual behavior:**

DSM-5 diagnostic criteria for manic episode

P.P.BMD

1) Inflated self-esteem or grandiosity.

2) Decreased need for sleep (feels rested after only 3 hours of sleep).

3) More talkative than usual or pressure to keep talking.

P.P.BMD

4) Flight of ideas or subjective experience that thoughts are racing.

5) Distractibility (attention too easily drawn to unimportant or irrelevant external stimuli), as reported or observed.

P.P.BMD

6) Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation (purposeless non-goal-directed activity).

7) Excessive involvement in activities that have a high potential for painful consequences (engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments).

P.P.BMD

P.P.BMD

- C. The mood disturbance is sufficiently severe to cause marked impairment in social or occupational functioning or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.

P.P.BMD

D. The episode is not attributable to the physiological effects of a substance (eg, a drug of abuse, a medication, other treatment) or to

P.P.BMD

A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased activity or energy, lasting at least 4 consecutive days and present most of the day, nearly every day.

DSM-5 diagnostic criteria for hypomanic episode

P.P.BMD

B. During the period of mood disturbance and increased energy and activity, 3 (or more) of the following symptoms (4 if the mood is only irritable) have persisted, represent a noticeable change from usual behavior, and have been present to a significant degree:

P.P.BMD

C. The episode is associated with an unequivocal change in functioning that is uncharacteristic of the individual when not symptomatic.

D. The disturbance in mood and the change in functioning are observable by others.

P.P.BMD

E. The episode is not severe enough to cause marked impairment in social or occupational functioning or to necessitate hospitalization. If there are psychotic features, the episode is, by definition, manic.

F. The episode is not attributable to the physiological effects of a substance (eg, a drug of abuse, a medication, or other treatment).

P.P.BMD

Anxiety

Comorbidity

Substance use

P.P.BMD

observations that major depression is the predominant type of bipolar mood episode during pregnancy

P.P.BMD

Mood labile

Preoccupation with newborn

Common symptoms

3%

P.P.BMD

among postpartum women, the 12-month prevalence of bipolar disorder

P.P.BMD

Pregnancy
39%

Antepartum
33%

Postpartum
28%

P.P.BMD

Postpartum bipolar mood episodes often progress rapidly the mean duration of episodes varies from approximately 1-3M

P.P.BMD

Hospitalization

- Psychotic features
- Aggressive behavior
- Impaired functioning (inability to care for oneself)
- Suicidal or homicidal ideation or behavior
- Substance dependence that is exacerbating the mood episode
- Poor judgement that places the patient or others at imminent risk of being harmed (neglecting the infant)

poor social support or previous severe m episodes

Onset of postpartum psychosis in bipolar occurs within the first two to three weeks of parturition

- Delusions
- Hallucinations
- Disorganized or bizarre behavior
- Disorganized thinki

MD

stpartum
BMD with
psychotic
F.

Cognitive impairment or confusion judgement
Agitation
Sleep disturbance
Mood lability
Impulsivity

increased risk for suicide and infanticide

R.F PP.Bipolar +psychotic F.

P.P.BMD

Delivery complic
breech presentation,
fetal distress, and cord
accidents

- Prenatal mood episodes
- Prenatal obstetric complications : hyperemesis, preeclampsia, and premature contractions

P.P.BMD

R.F PP.Bipolar +psychotic F.

- Primiparity
- History of prior puerperal psychosis

- Early age of onset of bipolar disorder
- Family history of bipolar disorder or postpartum psychosis

the risk for relapse during the postpartum period may be high, despite pharmacologic treatment.

P.P.BMD

70%

course of illness in bipolar patients with a lifetime history of postpartum mood episodes and patients without this history does not appear to differ.

However, the course of bipolar disorder may be more benign if the first lifetime mood episode (onset) occurs with a postpartum mood episode, rather than a nonpostpartum episode.

P.P.BMD

Lab test

P.P.BMD

- neuronal cell surface antibodies, including anti-N-methyl-D-aspartate receptor antibodies

Lab test

P.P.BMD

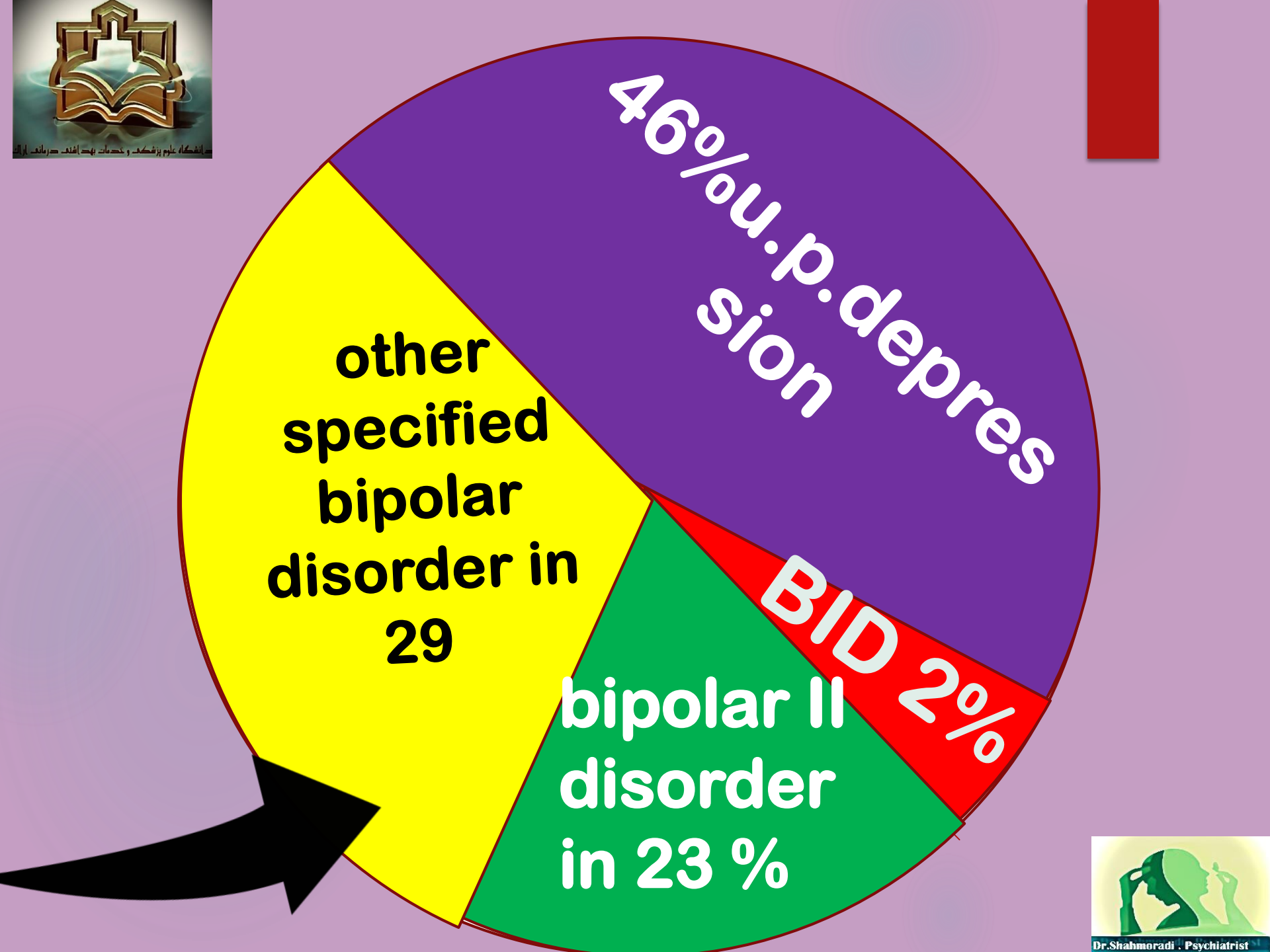
in patients with symptoms such as slurred speech, disorientation, memory deficits, dyskinesia, and/or seizures

Postpartum bipolar patients often present with a depressive syndrome and a prior history of hypomania or hypomanic symptoms is easy to miss

P.P.BMD

patients referred by nurse

family physicians, psychiatrists, and obstetricians to a perinatal psychiatric clinic for treatment of postpartum unipolar major


46%u.p.depres
sion
BID 2%
bipolar II
disorder
in 23 %
other
specified
bipolar
disorder in
29

Clinician

Decreased need for sleep as impaired or disrupted sleep

P.P.BMD

Excessive mood elevation as the normal elation of childbirth

The patient's lack of awareness of symptoms or poor insight

schizophrenia, schizoaffective

unipolar major depression,

substance use

autoimmune encephalitis, including anti-N-methyl-D-aspartate receptor encephalitis

The diagnostic approach toautoimmune encephalitis is discussed separate

P.P.BMD

We attempt to use drugs compatible with breastfeeding and doses at the low end of the therapeutic range, especially for infants less than three months of age, because their capacity to metabolize and clear medications is less than that of older infants

P.P.BM

avoid medications associated with weight gain and sedation (olanzapine) in postpartum bipolar patients.

P.P.BMD

For patients with mania (without psychotic features) or hypomania

ECT

Haloperidol

Risperidone

Olanzapine

carbamazepine or valproate,

P.P.BMD

refractory patients who do not respond

P.P.BMD

For patients with bipolar major depression who are breastfeeding and are not psychotic

valproate

efficacy
of quetiapine and olanzapine, valproate is generally regarded as compatible with lactation and there is more experience with valproate during breastfeeding than quetiapine and olanzapine

major depression with psychotic features who are breastfeeding, we suggest the antipsychotics quetiapine or olanzapine, rather than the anticonvulsant valproat

monotherapy is preferred over medication combinations (fluoxetine plus olanzapine) to minimize infant exposure

For refractory patients who do not respond, we suggest adding fluoxetine

P.P.BMD

ECT

ECT is generally safe and there are no absolute contraindications, even in patients whose general medical status is compromised

Postpartum patients with psychotic mania

P.P.BMD

Lactation

Hospitalized

Patients can breastfeed their babies provided that nursing staff are present; however, many patients are too disorganized and impulsive to breastfeed.

P.P.BMD

Benzodiazepine monotherapy

clonazepam or lorazepam

sleep
anxiety
agitation

For patients who remit with benzodiazepine monotherapy, a different drug (lithium) for maintenance treatment is started and titrated up. After the dose of the second drug is in the therapeutic range, the benzodiazepine is tapered and discontinued

P.P.BMD

Step 2:Antipsychotic +_ BZD 2-3w

monotherapy is a reasonable alternative to combination treatment, especially for patients who do not tolerate benzodiazepines, are breastfeeding and concerned about the risks to their infants, and patients with substance use

moderate to severe agitation, or patients with grossly disorganized behavior,

P.P.BMD

first-generation antipsychotics (haloperidol) or second-generation antipsychotics (olanzapine, quetiapine, or risperidone)

P.P.BMD

For patients who remit with a benzodiazepine plus an antipsychotic, the benzodiazepine is tapered and discontinued, and the antipsychotic is maintained. If patients do not respond to step 2, treatment advances to step

- Step 3 – Combination treatment with a benzodiazepine, antipsychotic, and lithium.

After two to three weeks, unresponsive patients receive a third round of step 3 treatment, either by switching lithium to valproate or switching antipsychotics. If patients do not respond to step 3 within 6 to 10 weeks, treatment advances to step

Valproate may be preferred by breastfeeding patients.

Step 4 = Electroconvulsive therapy (ECT).

pharmacotherapy was discontinued

the cumulative rate of remission at each step was 6, 25, and 98 percent of patients; none of the patients received step 4 (ECT).

P.P.BMD

P.P.BMD

low doses of drugs that have a short half-life and no active metabolites, such as lorazepam

For breastfeeding women who require benzodiazepines (eg, patients with severe anxiety or agitation

BZD

Postpartum psychosis

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P.P.psychosis

Postpartum psychosis constitutes a medical emergency, generally requiring rapid identification and intervention.

P.P.psychosis

rapid onset of psychotic symptoms including hallucinations and delusions, bizarre behavior, confusion, and disorganization that may appear to be delirium.

P.P.psychosis

medical emergency and generally requires rapid intervention and hospitalization

Hallucinations – Sensory experiences without physical sensory stimulation tactile, visual, auditory, gustatory, and olfactory sensations.

Delusions – Fixed, false, idiosyncratic beliefs that are not culturally based.

Thought disorganization.

P.P.psychosis

Disorganized behavior

P.P.psychosis

Postpartum psychosis is relatively rare, occurring in 1 to 2 per 1000 births, and is far less common than postpartum blues and postpartum depression

P.P.psychosis

risk of a hospital admission for psychosis to be increased during the first month postpartum (1.09 to 21.7) compared with any other time in a woman's life

P.P.psychosis

Postpartum psychosis has been strongly and consistently associated with bipolar disorder

50 percent or more of women with postpartum psychosis have no prior psychiatric history

Family history of postpartum psychosis.

History of postpartum psychosis

History of bipolar disorder, schizophrenia, or schizoaffective disorder

P.P.psychosis

previous hospitalization for bipolar disorder is strongly predictive of the development of postpartum psychosis

Risk factors

25 to 40 percent of deliveries in women with bipolar disorder are affected by postpartum psychosis

Family history of bipolar disorder.

First pregnancy.

Genetic

Immunology

P.P.psychosis

Hormonal

Etiology

sleep deprivation may be a factor in the development of postpartum psychosis.

P.P.psychosis

there is dysregulation of the immunoneuroendocrine set point in postpartum psychosis with over-activation of the monocyte and macrophage arm of the immune system

P.P.psychosis

There is no evidence of a link between stressful life events and thedevelopment of postpartum psychosis

P.P.psychosis

An increased risk of postpartum psychosis may be associated with D_2 receptor agonists (bromocriptine and cabergoline) used to suppress lactation, particularly in women with pre-existing psychiatric histories

There is no evidence of a link between stressful life events and the development of postpartum psychosis

P.P.psychosis

Postpartum psychosis most commonly presents within two weeks of childbirth. Persistent severe insomnia is often the first indication of an incipient postpartum psychosis

P.P.psychosis

Command auditory hallucinations may be present, instructing the mother to harm the baby or herself. When command hallucinations are present, the individual requires a higher level of care or hospitalization.

P.P.psychosis

rapid mood change

irritability

anxiety

psycho motor agitation

manic or depressed mood (or both)

severe insomnia

P.P.psychosis

In some cases, the patient may appear to be delirious (disorientation to person, place, or time), without evidence of cause

mental status may fluctuate between periods of confusion or perplexity and intermittent clearing.

In contrast, psychosis that is not associated with childbirth typically presents without disorientation to person, place, or time

P.P.psychosis

Delusion

postpartum psychosis tend to be related to the patient's mood state (in the depressed or mixed state, the believe that the baby is evil or that people are poisoning her).

olve their baby and are less bizarre than typically seen in schizophrenia.

P.P.psychosis

Course

P.P.psychosis

Episodes of postpartum psychosis can be severe and prolonged.

may interfere with maternal-infant bonding, which is also disrupted by inpatient hospitalization of the mother.

first-episode postpartum psychosis appear to have a high risk of recurrence outside of the postpartum

11 to 26 years

6.1 %experienced one or more subsequent episodes exclusively limited to the postpartum time period

43.5 %did not experience subsequent episodes and were classified as having “isolated postpartum psychosis

56.5 percent) experienced one or more subsequent episodes outside of the postpartum

P.P.psychosis

645 patients with a first psychosis episode postpartum

P.P.psychosis

DSM-5

does not classify postpartum psychosis as a distinct diagnostic entity. Instead, patients with postpartum psychosis are assigned a diagnosis based on their primary mental disorder, with the addition of the specifier “with peripartum onset” if onset of the current episode was during pregnancy or within four weeks postpartum.

DSM-5

P.P.psychosis

Major depressive disorder, with psychotic features, with peripartum onset. during pregnancy

- Bipolar disorder, current episode manic, with psychotic features, with peripartum onset
- Brief psychotic disorder, with postpartum onset (if the onset is during pregnancy or within four weeks postpartum

Women presenting for medical care during pregnancy or postpartum should be screened for current mental health problems, a history of psychiatric treatment, and a family history of mental illness.

P.P.psychosis

Patients screening positive for any of these items should be further assessed for a history of mania or hypomania, psychotic depression, or a psychotic disorder.

P.P.psychosis

Patients with a family history of psychiatric disorders should be queried further about a family history of hospitalization, suicide, mania, depression, or psychotic disorder.

P.P.psychosis

Patients with a personal or family history of one of these conditions should be educated and monitored during the first weeks of the postpartum period.

P.P.psychosis

P.P.psychosis

More intensive monitoring and prophylactic treatment should be considered for patients with a history of bipolar or schizoaffective disorder

P.P.psyc

Course

The onset and course of psychotic symptoms (episodic versus chronic)

The nature of the affective symptoms (depressed, manic, or mixed state, or not present)

The presence of passive death wishes, suicidal thoughts, and/or suicidal plans

The impact of these symptoms on the patient's behavior and functioning

The patient's history and family history of prior affective or psychotic episodes

P.P.psychosis

Safety of the child and others under the patient's care

The presence of a comorbid substance use disorder

medical causes of psychosis. The history should consider past and current general medical

P.P.psychosis

psychiatric conditions, current medications, and the use of alcohol and illicit substances. The physical examination should include a basic neurologic and mental status evaluation.

P.P.psychosis

Women with bipolar disorder are at high risk of recurrence in pregnancy and postpartum, which may present as postpartum psychosis

Risk factors

Women who discontinue mood stabilizers before or during the pregnancy may be at an increased risk of postpartum psychosis.

women without a prior history, a postpartum psychotic episode may be the first manifestation of bipolar disorder.

- family history of bipolar disorder should increase the suspicion for bipolar disorder in the patient, particularly if presenting with postpartum psychosis.

P.P.psychosis

P.P.psychosis

Schizoaffective disorder

D.D

Postpartum psychosis also presents with manic, depressive, or mixed episodes in schizoaffective disorder. The distinguishing feature of this disorder, compared with bipolar disorder, is the history or subsequent development of chronic psychosis without mood symptoms.

P.P.psychosis

Schizophrenia

D.D

20 to 25 percent of patient with schizophrenia will relapse during the postpartum time period

P.P.psychosis

This condition can present up to several months after delivery. The psychotic features occur in conjunction with severe depressive symptoms. The psychosis commonly takes the form of paranoid delusions of persecution.

D.D

Major depression with psychotic features

P.P.psychosis

Neither hallucinations nor agitation are common. Psychotic depression is often preceded by longstanding untreated postpartum depression. Clinically, it is then referred to as "late-onset postpartum psychosis."

Brief psychotic disorder with postpartum onset

sudden onset of delusions, hallucinations, or disorganized speech during pregnancy or within four weeks postpartum.

D.D

P.P.psychosis

duration of the episode is at least one day but less than one month with full return to premorbid level of functioning.

Substance use disorders

P.P.psychosis

D.D

Self-medication with drugs (including prescription drugs) and alcohol is a common complication of mood disorders, even in pregnant and postpartum women. Women with a prior history of a substance use disorder are at risk of relapse when they develop antepartum and postpartum mood disturbances. Psychosis can present as the result of substance intoxication or withdrawal.

Psychosis due to general medical conditions

P.P.psychosis

- Infectious diseases
  - Central nervous system
- Endocrine dysfunction
- Metabolic

D.D

P.P.psychosis

safety and initiating medications for psychosis, agitation, and insomnia are the initial priorities of clinical management.

P.P.psychosis

Important next steps include evaluation and testing to exclude other medical causes of psychosis, and diagnosing/starting treatment for an underlying psychiatric disorder

P.P.psychosis

Postpartum psychosis is typically treated with a combination of antipsychotic medication and a mood stabilizer.

Adjunctive psychotherapy can be useful and includes psychoeducation, support, coordination of care, and encouraging treatment adherence.

Safety

The first priority of treatment

usually be hospitalized until stable

mother should not be left alone with the infant.

separation of mother and baby at this critical time is not optimal

P.P.psychosis

P.P.psychosis

Women with mild to moderate illness may be able to breastfeed.

who are more severely ill may be too disorganized or present too much of a risk to the baby to breastfeed.

All psychotropic medications taken by the mother are transferred into breast milk and are passed on to the nursing infant.

The benefits of a psychotropic medication for the mother need to be weighed against risks to the infant from medication exposure.

P.P.psychosis

P.P.psychosis

The exposure of infants to antipsychotics via human milk generally appears to be low and clinically insignificant in the limited data available

P.P.psychosis

ECT

P.P.psychosis

suggest first-line treatment of patients with postpartum psychosis with one of the older, second-generation

P.P.psychosis

SGAs are generally preferred over FGAs due to lower rates of extrapyramidal symptoms [12] and tardive dyskinesia

P.P.psychosis

Risperidone

Olanzapine

Quetiapine

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P.P.psychosis

Haloperidol

P.P.psychosis

Benztropine (0.5 mg orally twice daily) is often administered in conjunction with FGAs to reduce extrapyramidal symptoms, though its safety in breastfeeding is unknown.

Agitation

P.P.psychosis

For mild agitation, 0.5 to 2 mg of haloperidol may be sufficient;

olanzapine

P.P.psychosis

Ziprasidone

Patients should be treated with an antipsychotic to remission. Treatment should be continued for at least one year to reduce the risk of relapse. Some patients will merit lifetime prophylaxis due to potential for relapse without medication and risk factors such as suicidality.

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Insomnia

P.P.psychosis

antipsychotic with a benzodiazepine rather than other medications

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P.P.psychosis

lorazepam

For women with postpartum psychosis who plan to breastfeed, we suggest treatment with valproate rather than lithium.

P.P.psychosis

PREVENTION

P.P.psychosis

Women with a history of bipolar disorder, a psychotic disorder, or a history of postpartum psychosis can be identified though screening during prenatal care

- Suicide
- Homicide (infanticide)

Economic

Congenital Problem

Risk factors

Female

Neonatcide

Low education

Poverty

Poor

Less19y

Preterm

Primipar

Single

Living at home with partner

Limited communication mother with family

Strict antiabortion law

Stigma of having illegitimate in unmarried

Psychiatry
illnesses
Psychosis

Disturbance balance of mind

95%of commit neonatcide deliver at home ond 15% resive any antenatal care

Infant homicide

M=F

Mother older than 25 y(avrage 34y)

Black population >wight

75%have psychiatric disorder

Alcohol and cocain use (antenatal,postnatal)

Munchiusen by proxy

Rumination about harming the baby can occur in postpartum depression

described as "scary thoughts," and are usually not revealed unless patients are questioned directlyThoughts of harming the baby are generally experienced as unacceptable (ego dystonic) and intrusive. However, these thoughts may indicate that patients are psychotic and should thus prompt an evaluation for psychotic symptoms such as delusions or hallucinations.

	2 to 7 per 100,000 infants Infanticide during postpartum depression may be more likely to occur in women who are psychotic or were previously admitted to a psychiatric hospital

- Mothers who kill their infants often try to kill themselves and one study found that among 80 postpartum women who committed suicide over a 15-year period, two killed their infant before killing themselves

	A case series of 10 mothers with postpartum depression who killed their infants found that the pregnancy was wanted and the baby was healthy, but that the women felt overwhelmed and were reluctant to be left alone with the baby

Homicidal behavior is rare in postpartum psychosis. Approximately a third of women hospitalized for postpartum psychosis expressed delusions about their infants, and 9 percent had thoughts of harming their infants

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

Disorganization and confusion in the mother add to the potential risks for the infant, who should not be left alone in the care of a mother with postpartum psychosis

Maternal suicide

Research suggests **suicide** is a **leading cause** of **maternal death** in the

1st year following childbirth.[1]

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Maternal **suicide** is **most frequently completed** between

6 to 12 months postpartum.[5]

Maternal **suicide deaths** are **more common** than maternal **deaths** caused by **postpartum hemorrhage** or **hypertensive disorders.**[2]

The severity and rapidly evolving nature of **postpartum psychosis increases the risk** of maternal suicide.[6]

Suicide accounts for up to 20% of postpartum deaths.[3/4]

Depression during pregnancy greatly **increases thoughts** about suicide **while pregnant.**[4]

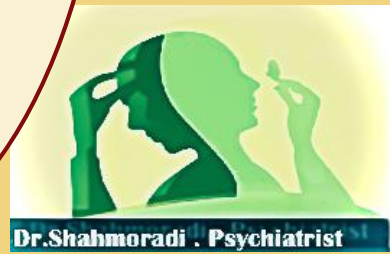
Cause of direct death in first year after the end of the pregnancy

Second direct marenal death during or with in 42 days of the end Of pregnan cy

The fifth most common cause of woman death during pregnancy

Postpartum depression
1-5/100000
Live birth

most were receiving mental health treatment but did not manifest suicidal ideas or endorse recent self-harm at the time of the last clinical contact, and the most had a primary diagnosis was depression



Postpartum BMD

active suicidal ideation, a specific plan, and intent to kill themselves may require constant observation. Outpatients are commonly seen on a weekly basis until they have responded (ie, the patient's safety has stabilized and the number, intensity, and frequency of psychotic and mood symptoms has improved substantially). Following response, patients can be seen every two to four weeks until they remit.

Bipolar patients with postpartum mood episodes may be at risk for suicide

Postpartum psychosis

baby is evil or that people are poisoning her

Postpartum psychosis

In the first year after childbirth, suicide increases 70-fold and is the leading cause of maternal death in the general population

Among women with first-episode postpartum psychosis, a systematic review and meta-analysis reported suicide rates as high as 4 to 11 percent

suicide prevalence was 4.62 times higher in women with low educational levels.

suicideWomen with comorbid depression or an anxiety disorder showed a 17.04times greater risk of suicide than those who did not suffer from any mood disorder.

A study of 1567 women who were admitted to a psychiatric hospital (diagnoses not specified) within one year of childbirth found that compared with the general population, completed suicide among admitted patients was 17 times higher

Fetal or infant death was associated with suicide attempts in postpartum women

Suicide attempt

a rate of approximately 44 attempts for every 100,000 live births;

Fetal or infant death was associated with suicide attempts in postpartum women

Suicide attempt

Women with a psychiatric disorder were at a 27.4-fold increased risk

Suicide attempt

substance use disorder were at a 6.2-fold increased risk

Suicide attempt

dual diagnosis were at an 11.1-fold increased risk of postpartum suicide attempt compared with controls.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