Postpartum Mood Disorders

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Postpartum Mood and Anxiety Disorders

Postpartum Blues
Postpartum Depression (PPD)
  – DSM-V: Postpartum onset specifier
  – Onset within 4 weeks of delivery
Postpartum Psychosis
Postpartum Episodes of Bipolar Disorder
Postpartum Anxiety Disorders or Symptoms
Postpartum Depression

- 10-15% of women experience major depressive episodes after delivery (25-40% of women with histories of MDD)

- Symptoms similar to non-puerperal major depressive episodes
  - Depressed mood, insomnia, fatigue, anhedonia, suicidal ideation
  - Anxiety is prominent, often marked obsessions, hypochondriasis are present

- Impairment of functioning

CDC, https://www.cdc.gov/mmwr/volumes/66/wr/mm6606a1.htm?s_cid=mm6606a1_w
Negative Effects of Maternal Depression on the Child

• Insecure attachment
• Behavioral problems
• Cognitive function
• Increased risk of abuse, neglect

• Childhood psychiatric diagnoses & symptoms
• Compliance with preventative measures
• Thoughts of harming infant

Civic & Holt, 2000; Cicchetti et al., 1988; Feldman et al., 1999; Murray et al., 1999; Murray et al., 1996; Sharp et al., 1995; Kotch et al., 1999; Cadzow et al., 1999; Jennings et al., 1999; McLennan & Kotelchuck, 2000; Weissman et al., 2006.
Postpartum Depression: Obsessions and Compulsions

• Obsessions are often present
• Obsessions more common than compulsions/rituals
• Obsessions more common in PPD (57%) than in non-puerperal MDD (36%)
• OCD in 9-11% of postpartum women
• 37.5% report subsyndromal OCD
• Aggressive obsessions > contamination > checking rituals

Differentiating OCD and Psychosis

• Postpartum OCD
  – Thoughts are ego-dystonic
  – Disturbed by thoughts
  – Avoid objects or being with their newborn
  – Very common disorder
  – Low risk of harm to baby

• Postpartum Psychosis
  – Thoughts are ego-syntonic
  – May not be distressed by thoughts
  – May not show avoidant behaviors
  – Not common disorder
  – High risk of harm to baby
Breastfeeding

• ...The experience of breastfeeding is special for so many reasons – the joyful bonding with your baby, the cost savings, and the health benefits for both mother and baby...

• ...Time to declare an end to the breastfeeding dictatorship that is drowning women in guilt and worry just when they most need support...

Gayle Tzemach Lemmon, Breastfeeding is a Choice, Let’s Treat it that Way
Postpartum Depression: Etiology and Risk Factors
Risk for Postpartum Depression: Hormonal Variables

• Inconsistent findings: no one hormone has been implicated in the cause of PPD

• Thyroid dysfunction is common

• Behavioral sensitivity to gonadal steroids in women with PPD has been demonstrated
  – Models of hormone withdrawal to simulate postpartum hormonal decreases in estrogen and progesterone can reproduce depressive symptoms in small studies of women with histories of PPD (Bloch Am J Psychiatry 2000)
Postpartum Depression Predictors Inventory

**Stronger Predictors:**
- History of depression
- Depression in pregnancy
- Anxiety in pregnancy
- Stressful life events
- Marital dissatisfaction
- Child care stress
- Inadequate social supports
- Difficult infant temperament
- Low self-esteem
- Family History of Postpartum Depression – heritability 44-54% (from twin and sibling studies)

**Weaker Predictors:**
- Unwanted or unplanned pregnancy
- Lower socioeconomic status
- Being single
- Postpartum blues
Risk for Postpartum Illness: History of Psychiatric Illness

- Depression during pregnancy is a robust predictor of postpartum illness
- History of PPD or PP psychosis: 50-70% risk of recurrence
- History of bipolar disorder: 30-50% risk of PP illness
- History of recurrent MDD: Up to 30% risk of PPD

Screening for Postpartum Depression
Postpartum Psychiatric Illness: Detection

- PPD is frequently missed
- Overlap with “normal” postpartum experience: decreased sleep, fatigue, overwhelmed, anxiety (“normal” or not)
- Multiple contacts with health care providers provides opportunity for detection
- Several states have already implemented universal screening or are in the process of implementing screening
- Many options:
  - Edinburgh Postnatal Depression Scale (EPDS): frequently used, 10-item, self-rated

Screening for Depression in Adults
US Preventive Services Task Force Recommendation Statement

DESCRIPTION Update of the 2009 US Preventive Services Task Force (USPSTF) recommendation on screening for depression in adults.

METHODS The USPSTF reviewed the evidence on the benefits and harms of screening for depression in adult populations, including older adults and pregnant and postpartum women; the accuracy of depression screening instruments; and the benefits and harms of depression treatment in these populations.

POPULATION This recommendation applies to adults 18 years and older.

RECOMMENDATION The USPSTF recommends screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up. (B recommendation)

Postpartum Depression Screening

PPD Screening:

1) Does it translate into treatment engagement?

2) Does it yield better outcomes?
Pitfalls: Risks of Screening Without a Net

Screening itself does not lead to better outcomes

- Low rates of treatment engagement
- Low rates of follow-up on referrals, especially if mental health treatment is offsite
- Sparse data on outcomes after screening and referral

Screening must be accompanied by:

- Adequate numbers of well-trained treaters to provide assessments and care
- Care needs to be available and delivered in a timely fashion
- Treatment options must reflect heterogeneity of depression detected and patient preferences

Perinatal Depression Treatment Cascade

• Antenatal (AND) and postpartum depression (PPD): Mean rates of diagnosis, treatment, adequate treatment, and remission were calculated and weighted based on the number of subjects in each study.

• Decrements occur at each branch of the cascade.
  – 49.9% of women with AND; 30.8% with PPD are identified in clinical settings;
  – 13.6% of women with AND and 15.8% with PPD receive treatment;
  – 8.6% with AND and 6.3% with PPD receive adequate treatment;
  – 4.8% with AND and 3.2% with PPD achieve remission.

Cox et al., J Clin Psychiatry 2016
Postpartum Depression:
Treatment
Treatment Recommendations: Postpartum Depression

• Moderate to severe depression
  – Consider role of antidepressants; discuss risks and benefits with mother

• Use lowest effective doses
• Consultation with experts
• Maximize non-medication alternatives
Postpartum Depression: Non-Pharmacologic Strategies

• Maximize social supports
• Psychoeducation of patient and family members
• Group therapy and support groups
• Interpersonal therapy (IPT)
• Cognitive-behavioral therapy (CBT)
  – Similar results: fluoxetine vs. 6 sessions CBT

## Antidepressant Trials for the Treatment of PPD

<table>
<thead>
<tr>
<th>Study</th>
<th>Design and Size</th>
<th>Medication studied, result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appleby et al., 1997</td>
<td>Placebo-controlled, N=87</td>
<td>Fluoxetine - superior to placebo</td>
</tr>
<tr>
<td>Yonkers et al, 2008</td>
<td>placebo controlled, N=70</td>
<td>Paroxetine - not superior to placebo)</td>
</tr>
<tr>
<td>Wisner et al., 2006</td>
<td>RCT, Setraline vs. Nortriptyline, N=109</td>
<td>Sertraline vs. Nortriptyline - no significant difference</td>
</tr>
<tr>
<td>Hantsoo et al., 2013</td>
<td>Placebo-controlled RCT, N=36</td>
<td>Setraline - superior to placebo</td>
</tr>
<tr>
<td>Bloch et al., 2012</td>
<td>N=40, all received brief psychodynamic therapy, RCT to sertraline or placebo</td>
<td>Both groups improved – no significant difference for sertraline vs. placebo</td>
</tr>
<tr>
<td>Sharp et al., 2010</td>
<td>RCT, AD selected by general practitioner or counseling, N=254</td>
<td>Antidepressants - superior to placebo</td>
</tr>
<tr>
<td>Misri et al., 2012</td>
<td>Open trial, N=15</td>
<td>Citalopram – open study</td>
</tr>
<tr>
<td>Misri et al., 2004</td>
<td>N=35, all received parox, half randomized to CBT also</td>
<td>Paroxetine – no control group</td>
</tr>
<tr>
<td>Stowe et al., 1995</td>
<td>Open-label; N=21</td>
<td>Sertraline – open study</td>
</tr>
<tr>
<td>Cohen et al., 1997</td>
<td>Open-label; N=19</td>
<td>Venlafaxine- open study</td>
</tr>
<tr>
<td>Suri et al., 2001</td>
<td>Open-label; N=6</td>
<td>Fluvoxamine - open</td>
</tr>
<tr>
<td>Nonacs et al., 2005</td>
<td>Open-label; N=8</td>
<td>Bupropion- open</td>
</tr>
</tbody>
</table>
Antidepressant Treatment During Breastfeeding

Most studies of infant exposure to antidepressants show low levels of drug in breast milk and infant serum
Weissman et al., 2004; Burt et al., 2001

Few case reports of adverse effects:

Doxepin: infant had clinical effects of vomiting, sedation (Frey et al., 1999)
Fluoxetine: Case report of high infant blood levels, colicky symptoms (Lester et al., 1993)
  – In women who took Fluox during pregnancy, followed postpartum while nursing: slower infant growth in non-randomized study (Chambers et al., 1999)
Citalopram: sleep trouble in infant (Schmidt et al., 2000)
Nefazodone: Case report: drowsiness, lethargy, inability to maintain body temp in a premature baby (Yapp et al., 2000)
Bupropion: possible seizure in an infant (Chaudron et al, 2004)
<table>
<thead>
<tr>
<th>Antidepressant</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fluoxetine</td>
<td>Due to long half life, may be more likely to be found at detectable levels in infant serum, especially at higher doses.</td>
</tr>
<tr>
<td></td>
<td>• Reasonable for use if a woman has had a good previous response to it and reasonable to consider if used during pregnancy.</td>
</tr>
<tr>
<td>Sertraline</td>
<td>• Consistent reports of low levels of exposure, relatively large amount of study</td>
</tr>
<tr>
<td>Citalopram, escitalopram</td>
<td>• Less systematic study of mom-baby pairs compared with sertraline and paroxetine, observed low levels of exposure to infant via breastfeeding</td>
</tr>
<tr>
<td>Paroxetine</td>
<td>• Consistent reports of low levels of exposure, relatively large amount of study</td>
</tr>
<tr>
<td></td>
<td>• Use limited by commonly experienced withdrawal symptoms, maybe more sedating than other SSRIs</td>
</tr>
<tr>
<td>Bupropion</td>
<td>• Paucity of systematic study; a few case reports in older infants that demonstrate low levels of exposure via breastfeeding</td>
</tr>
<tr>
<td></td>
<td>• May be advantageous in smokers</td>
</tr>
<tr>
<td></td>
<td>• Reasonable for use if women have had good previous response</td>
</tr>
<tr>
<td></td>
<td>• One case report of possible infant seizure</td>
</tr>
<tr>
<td>Venlafaxine, Desmethyl</td>
<td>• Higher levels of desmethylvenlafaxine found in breastmilk than venlafaxine</td>
</tr>
<tr>
<td>Venlafaxine</td>
<td>• No adverse events reported</td>
</tr>
<tr>
<td>Tricyclic Antidepressants</td>
<td>• Considered reasonable for breastfeeding if use clinically warranted; few adverse affects in babies and generally low levels of exposure reported</td>
</tr>
<tr>
<td>Mirtazapine, nefazodone, MAOIs, duloxetine</td>
<td>• Systematic human lacking in the context of breastfeeding</td>
</tr>
</tbody>
</table>
Anxiety - benzodiazepines

- Severe anxiety often warrants acute treatment
  - SSRIs have a delayed onset of efficacy
  - Benzodiazepines can be used prn
  - Lorazepam and clonazepam considered preferable to alprazolam (LactMed)
  - Limited study; case series demonstrate low levels of passage into breastmilk and infant serum (Birnbaum et al., Pediatrics 1999; LactMed)
Sleep meds & breastfeeding

- Zolpidem – small number of cases with low levels of infant exposure (LactMed)
- Sedating antidepressants – some data for tricyclics, mirtazapine
- Antihistamines
- Supplements?
  - No data for melatonin supplementation
  - Valerian root not recommended during breastfeeding
Prevention of Postpartum Depression
### RCTs of Antidepressants for Prevention of PPD in women at risk

<table>
<thead>
<tr>
<th>Study</th>
<th>High Risk defined by...</th>
<th>Intervention</th>
<th>N</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wisner et al., 1994</td>
<td>Past h/o postpartum MDD</td>
<td>Open trial; monitoring alone vs. monitoring + a medication that had been effective for the previous episode or nortriptyline (pt selected monitoring vs. monitoring + med)</td>
<td>N=23; monitoring compared to medication + monitoring</td>
<td>Significantly greater proportion of the women who elected monitoring alone (62.5 percent) suffered recurrence compared to monitoring plus medication (6.7 percent) (p = .0086)</td>
</tr>
<tr>
<td>Wisner et al., 2001</td>
<td>Past h/o postpartum MDD</td>
<td>RCT: Nortriptyline vs. placebo (started immediately postpartum) x 20 wks</td>
<td>N=51 (N=26 Nortrip; N=25 placebo)</td>
<td>No significant differences between groups; <strong>about 25% recurrences for both</strong> (6/25 relapsed on placebo; 6/26 on nortrip)</td>
</tr>
<tr>
<td>Wisner et al., 2004</td>
<td>Past h/o postpartum MDD</td>
<td>RCT: Sertraline v. Placebo (started immediately postpartum) x 17 wks (followed for 20 wks)</td>
<td>N=22 (N=14 sert, N=8 placebo)</td>
<td>7% recurrence with sert; <strong>50% recurrence with placebo</strong> (significantly different)</td>
</tr>
</tbody>
</table>
PPD Prevention: non-pharmacologic

• Interpersonal Psychotherapy
• Cognitive behavioral therapy
• Groups and individual psychotherapies

Zlotnick et al., 2016, Werner et al., 2014; Kozinsky et al., 2012
Brexanolone (SAGE-547)  
Allopregnanolone/Neurosteroids

- Allosteric modulator of GABAa receptors
- New Drug Application pending at FDA
- Phase 2 trial of SAGE-547 for the treatment of severe PPD; results of Phase 3 trial pending
  - >26 on the Hamilton Depression Rating Scale (HAM-D); onset between third trimester and 1 month postpartum
  - Randomized to SAGE-547 (n=10) or placebo (n=11); blinded infusion over 60 hours
  - At 24 hours, participants receiving SAGE-547 experienced a 19.0 point mean reduction in their HAM-D scores (p=0.006), compared to 8.4 points in the placebo group; 7/10 participants receiving SAGE-547 achieved remission, at 60 hours, as compared to 1/11 placebo patients (p=0.008)

- Positive phase 3 data per press release, publication pending

Kanes SJ, et al. *Hum Psychopharmacol.* 2017;32(2); Kanes et al., Lancet 2017
Bipolar Disorder: Postpartum Considerations
Viguera, et al. 2000:

- Retrospective comparison of recurrence rates, pregnant (N=42) vs. nonpregnant women (N=59) with bipolar disorder.
- Rates of recurrence after discontinuation of medication:
  - Similar for pregnant and nonpregnant women, except more depressive episodes in pregnant women (overall recurrence rate = 55%).
  - Women at increased risk of recurrence postpartum (70% vs. 24%; 2.9 x more likely to have recurrence than nonpregnant women after same time course).
  - Recurrence risk greater after rapid discontinuation (≤2 wks) than gradual (2-4 wks).
Risk of Psychiatric Hospitalization During Pregnancy and Postpartum


Highest risk of hospitalization for new mothers 10-19 days postpartum, increased outpt contacts 1st three months

—Munk-Olsen et al., *JAMA*, 2006
Postpartum Psychosis
Postpartum Psychosis

- 1 to 2 per 1000 pregnancies
- Rapid, dramatic onset within first 2 weeks
- High risk of harm to self and infant
- **Suspect Bipolar disorder:**
  - Underlying diagnosis: affective psychosis (bipolar disorder or schizoaffective disorder)
  - Family and genetic studies, index episode follow-up

Nonacs and Cohen, 1998; Jones & Craddock, 2001; Spinelli, AJP, April 2009
Diagnosis?

• Majority have bipolar disorder or schizoaffective disorder (72-80%)
• Schizophrenia (12%)
• More likely to be related to an affective disorder than not
• Risk factors:
  – history of postpartum psychosis
  – previous psychosis
  – bipolar disorder
  – previous psychiatric hospitalizations

Spinelli, AJP, 2004
Postpartum Psychosis

• Psychiatric emergency
• Estimated that 4% of women with postpartum psychosis commit infanticide
  – Actual rates of infanticide are difficult to estimate, as infanticide may be under-reported

Spinelli, AJP 2004; Spinelli, AJP 2009
<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>% that developed postpartum psychosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitalization for psychotic episode during the pregnancy</td>
<td>44%</td>
</tr>
<tr>
<td>Hospitalization for a past psychotic episode prior to the pregnancy</td>
<td>14.5%</td>
</tr>
<tr>
<td>Any previous psychiatric hospitalization</td>
<td>9.2%</td>
</tr>
<tr>
<td>Previous hospitalization for bipolar mood episode</td>
<td>2.0%</td>
</tr>
<tr>
<td>Baseline population risk</td>
<td>0.07%</td>
</tr>
</tbody>
</table>

Harlow et al, Arch Gen Psychiatry 2007
Acute Treatment

- Inpatient psychiatric hospitalization
- Rule out medical conditions
- Length of stay depends on clinical condition
- Many women will need to stop breastfeeding
- Primary pharmacotherapy: mood stabilizer and an antipsychotic, with medications for anxiety, insomnia, and agitation as needed
  - Sequential use of benzodiazepines, antipsychotics, lithium and ECT proposed

Sit et al., J Women’s Health, 2006; Bergink et al., AJP 2015
Acute Treatment

• Inpatient Protocol: Sequential use: N=64
  • Step 1: Benzodiazepine (lorazepam), 3 days - 6% remitted (N=4)
  • Step 2: Antipsychotic: haloperidol or atypical – 19% remitted (N=12)
  • Step 3: lithium – 73% remitted (N=48)
  • Step 4: ECT – none underwent
  • Total of 98% remission; only 1 patient did not fully remit
    – Most women responded to by addition of lithium
  • Sustained remission at 9 months postpartum in 80%
    – Affective diagnosis more associated with remission than non-affective
    – Relapse rates higher with antipsychotics than with lithium

Bergink et al., AJP 2015
Treatment After Discharge

- Little data to inform length of care
  - 6-12 months of pharmacotherapy
  - psychotherapy and close monitoring

- Treatment planning for adequate sleep, support, help in meeting the needs of caring for a baby

- Close monitoring is required for safety
  - Psychoeducation of family and friends
Postpartum Relapse: Bipolar Disorder

- Pharmacotherapy strongly influences rate of postpartum relapse; medication use in pregnancy reduces risk
- If medication is discontinued, restarting immediately after delivery or in the third trimester greatly reduces risk of recurrence
- Review: 37 articles (N=4,023 patients):
  - Overall postpartum relapse risk was 35% (95% CI=29, 41)
  - History of postpartum psychosis predicted severe postpartum episodes than history of bipolar disorder without postpartum psychosis history
  - In women with bipolar disorder, postpartum relapse rates significantly higher among those who were medication free during pregnancy (66%, 95% CI=57, 75) than those who used prophylactic medication (23%, 95% CI=14, 37)

Prevention of Postpartum Psychosis

• Are outcomes different in women who have only had postpartum psychotic episodes and no other mood episodes?
• When should medication prophylaxis be initiated?
  – Most using lithium
  – Advised to use lithium prophylaxis immediately after delivery

Bergink et al., AJP 2012
Main points

• History of isolated postpartum psychosis
  – High risk for recurrence postpartum
  – Prophylaxis may be deferred to immediately postpartum if mother well throughout pregnancy

• Bipolar disorder
  – High risk for recurrence throughout pregnancy and the postpartum, particularly with medication discontinuation
  – High risk postpartum relapse, postpartum prophylaxis decreases risk
  – Clinical picture during pregnancy greatly factors into postpartum prognosis – do not delay treatment
Postpartum Treatment

• **Prescribe Sleep!**
  – Sleep deprivation – similar to antidepressants regarding risk of induction of mania/hypomania (10%)

• **Prescribe Support!**
  – Good social support associated with quicker recovery, less symptomatic; better prophylaxis against episodes

Mood Stabilizers & Breastfeeding:
Lithium

- **Lithium**
  - Toxicity reported in cases with infant serum levels at 0.1-0.5 times the maternal level
  - Contraindicated at one time by the American Academy of Pediatrics

- **Lithium and Breastfeeding**
  - N=10 mother-baby pairs;
    - Mother’s stable, lithium monotherapy 600-1200 mg q day
    - Babies’ serum levels 0.09-0.3 meq/L (average 0.16)
    - Transient increases in elevated infant TSH, BUN, Cr

  - **Recommendations** – might consider breastfeeding when
    1) Bipolar disorder in mother that is stable
    2) Lithium monotherapy (or simple regimen)
    3) Adherence to infant monitoring
      - Monitoring Li level, TSH, BUN, Cr immediately postpartum, 4-6 weeks of age, and then every 8-12 weeks
    4) Healthy infant
    5) Collaborative pediatrician

American Academy of Pediatrics 2001; Viguera et al., 2007
Mood Stabilizers & Breastfeeding: Lamotrigine

- Generally higher levels in breastmilk and infant blood levels than seen with antidepressants but considered compatible with breastfeeding
- Good number of mother-baby pairs in published literature
- The largest study to date examining lamotrigine in breast milk, maternal breast milk and mother and baby blood levels were collected for 30 mothers and included 210 breast milk samples
  - Infant plasma concentrations were 18.3% of maternal plasma concentrations.
  - Mild thrombocytosis (higher than normal platelet counts) in 7 of 8 infants at the time of sampling.
  - No other adverse events were observed or reported in the breastfed infants.
  - The authors concluded that consistent with previous investigations of medications in breast milk, the lamotrigine milk/plasma ratio is highly variable.
  - Lamotrigine appears relatively comparable in terms of nursing-infant exposure compared with other antiepileptic drugs.
- No reports of infant rash

Newport et al., Pediatrics 2008
Benzodiazepines and Breastfeeding

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  – SSRIs have a delayed onset of efficacy
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Ask About Birth Control Methods and Document Interactions with Oral Contraceptives Pills (OCPs)

- May Decrease Efficacy of OCPs:
  - Carbamazepine
  - Oxcarbazepine
  - Topiramate
  - St John’s Wort
  - Modafinil, armodafinil

- Oral contraceptives may decrease lamotrigine levels
Postpartum Mood Disorders: Summary

• The postpartum is a vulnerable window of time for many women
• Women, children, and families are impacted
• Effective, safe, accessible, and acceptable treatments are needed
• Treatment considerations involve risks of medications, risks of the untreated disorder
• Unknowns
  • Warrant collaborative treatment decisions, prioritizing patient preferences