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Postpartum Psychiatric Disorders

Passion profession same

Symptoms of postpartum psychiatric disorders[1]

Immediately after delivery	10–14 days after delivery	2–3 months after delivery
• Likely transient depression ("postpartum blues")[2]	• Likely transient depression ("postpartum blues")[2] • Exclude postpartum psychosis[3]	• Likely postpartum depression[6]
Outpatient management	Inpatient management of psychosis[4]	Outpatient management
• Supportive care • Monthly follow-up	• Admit to acute psychiatric inpatient unit • Initiate antipsychotic medications • *Consider ECT, if indicated*	• Supportive care • Monthly follow-up • Continue breastfeeding[5]
Good response: • Continue supportive care and regular follow-up	Discharge once stabilized: • Supportive care • Monthly follow-up • Continue breastfeeding[5]	Good response: • Continue supportive care and regular follow-up
Poor response: • Consider referral to a psychiatric care provider, if indicated • Consider short-term psychotherapy and/or psychopharmacology[7]		Poor response: • Consider referral to a psychiatric care provider, if indicated • Consider short-term psychotherapy and/or psychopharmacology[7]

1. Pregnancy is generally thought of as a time of universal well-being. However, in women with established psychiatric disorders, pregnancy may exacerbate their symptoms.

2. A patient's underlying psychiatric diagnosis as well as her social, cultural, and educational background will often determine her emotional adjustment to being pregnant. In general, pregnancies that are planned and/or desired create fewer conflicts within the individual and as such are better accepted.

3. The puerperium has long been identified as a time of increased risk for mental illness. This is due in part to discontinuation of medications during pregnancy because of concern over the safety of the fetus.

4. A mild transient depression ("postpartum blues" or "maternity blues") is common immediately after delivery, occurring in >50% of all postpartum women. The etiology of this disorder is unclear, but is likely due to the rapid biochemical and hormonal changes associated with childbirth.

5. Severe postpartum psychotic depressive or manic illness is rare (1–2 per 1000 livebirths). Risk factors include younger age, primiparity, a family history of mental illness, and most importantly a personal history of psychotic illness. The risk of recurrence in a woman with a history of prior postpartum psychosis is 25–30%. The peak onset of psychotic symptoms is typically 10–14 days after delivery.

1. In patients with postpartum psychosis, pharmacologic therapy should be initiated as soon as possible and short-term hospitalization may be necessary.
2. Electroconvulsant therapy (ECT) has been used in this setting with some success. Many of these women go on to develop life-long depressive disorders. Interestingly, suicide is uncommon during pregnancy and the year following delivery. Recurrence of postpartum psychosis is high (25–30%).

3. All psychotropic drugs are excreted in breast milk. The milk-to-plasma ratio of antidepressants ranges from 0.5 to 1.0, whereas only 40% of lithium is excreted in breast milk. In general, the amount of medication ingested by the baby is small. For this reason, the American Academy of Pediatrics (1983) has concluded that antipsychotic drugs and lithium are compatible with breastfeeding. However, the metabolism of drugs is impaired in infants due to hepatic immaturity.

4. This is especially true for premature infants, and in this cohort it may be prudent to withhold breast milk if high doses of medication are required. An alternative recommendation has been to continue breastfeeding, but to monitor maternal and infant blood levels and discontinue feeding only if the drug levels are dangerously elevated or if the infant develops signs of toxicity.

1. Nonpsychotic postpartum depression complicates approximately 8–15% of all pregnancies, but the incidence may be as high as 30% in women with a prior history of depression and upwards of 70–85% in women with a previous episode of postpartum depression. Symptoms typically start between 2 and 3 months after delivery.

2. Prophylactic pharmacotherapy should be considered in women at high risk of postpartum depression or psychosis. Unfortunately, depressive illness is only identified in around one-third to one half of postpartum patients who meet Diagnostic and Statistical Manual (DSM)-V diagnostic criteria.

3. The natural history of a postpartum depressive episode is one of gradual improvement over the 6–12 months following delivery.
4. Supportive care and monthly follow-up for the first 3–6 months (watching for symptoms and signs of worsening depression, thoughts of infanticide or suicide, emergence of psychosis, and response to treatment) may be all that is required.