Postpartum Psychiatric Disorders (PPDs)

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Topics

- Introduction
- Epidemiology
- Mechanisms/pathophysiology
- Genetic factors
- Psychosocial factors and comorbidities
- Other factors
- Diagnosis
- Prevention
- Management
- Treatment
- Conclusion
- Reference

Introduction

An increased risk of the onset or worsening of psychiatric illness, including mood disorders, anxiety disorders and psychosis, exists during the first 3 months postpartum.

The PPDs include:

- **Postpartum Depression (11%)**
- **Anxiety Disorders (15%)**
- **Post-Traumatic Stress Disorder (PTSD)**
- **Postpartum Psychosis**
- **Eating Disorders**
- **Obsessive–Compulsive Disorder (OCD)**

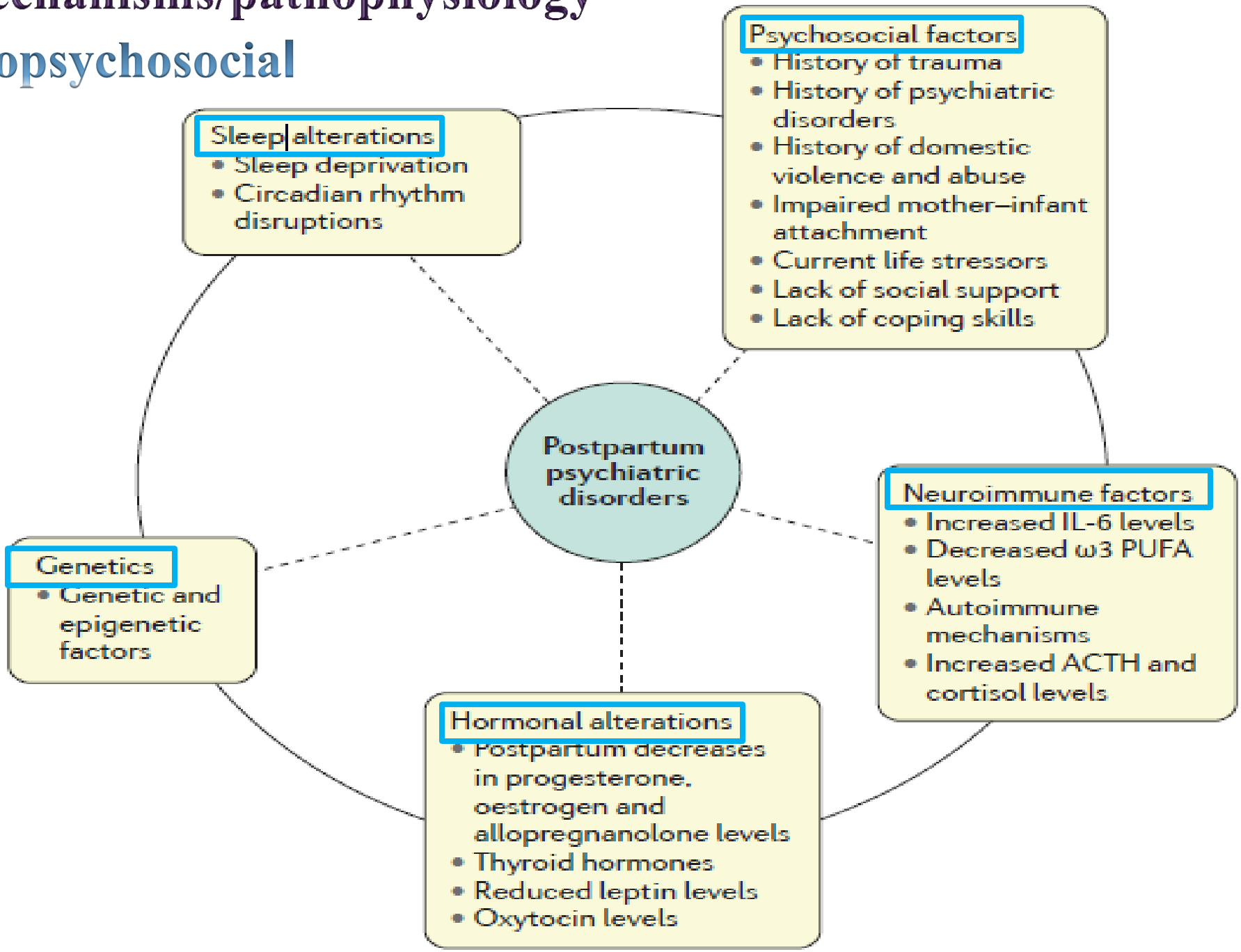
Epidemiology

- **Postpartum depression**
  - 13% in high-income countries
  - ~20% in low-income & middle-income
- **Postpartum mood disorders**
  - Part of mood disorders
- **Postpartum anxiety**
  - 35% in women with a history of eating disorder
  - ~10% AD & 6% GAD
- **Postpartum psychosis**
  - ~1 in 1,000 childbirths
  - 37% in bipolar disorder
  - ~ 16% in other psychiatric disorders

Suicide between 9 & 12 months postpartum

Mechanisms/pathophysiology

Biopsychosocial



Genetic factors

- The role of genetic factors in depression
- Psychological stressors and early life adverse events have a lasting negative effect and can result in pathophysiological changes and altered gene expression owing to increased **allostatic** load.
- Epigenetic alterations have been demonstrated in two genes:

HP1BP3

TTC9B

Psychosocial factors and comorbidities

- Psychological and social stressors
- Lack Social support
- history of a mood disorder
- domestic violence
- history of abuse
- marital difficulties
- migration status
- antenatal depression or anxiety
- Poverty

- young age
- Substance
- increased parity
- multiple births
- an unwanted pregnancy
- Neuroticism
- pregnancy complications
- obesity and comorbidities
- neonatal problems

Other factors

- Sleep disruption
- Reproductive hormones
- Stress axis
- Thyroid hormones
- Neuroimmune pathways

Diagnosis

- Biopsychosocial assessment

Prevention

- Assessment of risk factors
- Some psychological interventions
- Focus of IPT
- Pharmatherapy

Management

- The goals of treating mental illness in the postpartum period are to reduce maternal psychiatric symptoms and to support maternal–child and family functioning.
- Optimize Social support
- obtaining sleep and a stable circadian rhythm
- Psychotherapy & pharmatherapy

Treatment

Mood disorders and anxiety

- ***Psychological interventions:***

CBT

IPT

- ***Drug therapies:***

SSRIs

SNRIs

Sertraline

Mirtazapine

- ***Other treatments:***

hormonal treatments

Complementary and alternative treatments

ECT

Postpartum psychosis

- psychiatric hospitalization
- women with known severe psychiatric illness with non-perinatal episodes
- women without a history of bipolar disorder or other severe psychiatric disorder

The largest study (consisting of 68 patients) demonstrated the efficacy of a stepwise sequence of short-term benzodiazepines, antipsychotics and lithium and showed remission in 98.4% of patients in the acute phase.

The second-largest study described successful ECT treatment in 34 patients with postpartum psychosis of whom many had symptoms of catatonia.

antipsychotics:

- **Risperidone**
- **Quetiapine**
- **olanzapine**
- **Anticonvulsants as mood stabilizers**
- **lamotrigine**

conclusion

- PPDs are morbid and costly disorders. Advocating for early identification and screening that begins in pregnancy to identify women at risk, in addition to timely and effective treatment of PPDs, is essential.
- Although genetic, biological and hormonal signals likely have an important role in the risk of postpartum mood disorders, psychosocial contributions, including the effect of lifetime stressors, must be part of a comprehensive work-up and treatment plan.

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Thanks for your attention