First Annual Bay Area Maternal Mental Health Conference:

Psychotherapy and Nonpharmacologic Treatment Modalities, Risk Factors for Psychiatric Illness and “The Difficult Patient”

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Lecture Goals

• Identification of Women at Risk for Perinatal Mood Disorders
• Review Psychotherapy and Nonpharmacologic Treatments for Perinatal Mood Disorders
  • Rationale
  • Evidence basis
  • Unique challenges
  • Future research directions
• “Difficult patients”
  • Differential diagnosis and treatment options
Screening to Improve PPD Recognition/Treatment

Risk Factors for Perinatal Mood Disorders

- Anxiety during pregnancy
- History of Major Depression
- History of abuse
- Pregnancy Complications
- Domestic Violence
- Substance Abuse
- Breast Feeding Problems
- Infant Sleep Problems


**OBGYN**
- Poor maternal self care
- Pregnancy Complications

**Pediatrician**
- Infant Sleep Problems
- Irritability

**Psychiatrist**
- History of Anxiety/Depressive Disorder

**PCP**
- Unexplained somatic concerns
- Domestic abuse

**“Universal Screening” vs. Screening Select Groups**

Asking the Right Questions in the Right Places

Review: Rhodes, A and Sebre L. *Arch Women’s Ment Health* 2013
The Evolving Field of Perinatal Mood Disorders Research

Demographic and Clinical Variables
- Age
- Socioeconomic factors
- Prior Psychiatric History
- Family History of Depression

Psychosocial Variables
- Stressful Life Events
- Partner Support

Specific Populations at Risk
- High Risk OB Populations
- Anxiety Disorders including Subclinical

Specific Personality Types and Attachment Styles at Risk

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## PPD: Personality Characteristics

<table>
<thead>
<tr>
<th></th>
<th>Major PPD</th>
<th>Controls</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N=122</td>
<td>N=115</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>High Perfectionism Total Score</td>
<td>33.6</td>
<td>10.4</td>
</tr>
<tr>
<td>High concern over mistakes</td>
<td>33.6</td>
<td>7.8</td>
</tr>
<tr>
<td>High personal standards</td>
<td>24.6</td>
<td>12.2</td>
</tr>
<tr>
<td>High parental criticism</td>
<td>37.7</td>
<td>12.2</td>
</tr>
<tr>
<td>High doubt about actions</td>
<td>22.1</td>
<td>5.2</td>
</tr>
<tr>
<td>High parental expectations</td>
<td>23.8</td>
<td>16.5</td>
</tr>
<tr>
<td>High organization</td>
<td>40.2</td>
<td>33.0</td>
</tr>
</tbody>
</table>

The Percent of Physicians Who Correctly Diagnosed 5 Clinical Vignettes

<table>
<thead>
<tr>
<th>Vignettes Correct Diagnosis</th>
<th>Correct (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>92.2</td>
</tr>
<tr>
<td>Panic disorder</td>
<td>54.9</td>
</tr>
<tr>
<td>Generalize anxiety disorder (GAD)</td>
<td>32.3</td>
</tr>
<tr>
<td>No clinical diagnosis 1</td>
<td>29.4</td>
</tr>
<tr>
<td>No clinical diagnosis 2</td>
<td>8.5</td>
</tr>
</tbody>
</table>

Why Psychotherapy?

- Preferred treatment for depression in nonpregnant depressed women and men\(^1,2\)
- Preferred treatment for perinatal depression by:
  - Women\(^3-6\)
  - ? Partners
  - ? Health Care providers
- Improved treatment compliance?\(^7\)

What is the evidence that psychotherapy is an effective treatment for depressed perinatal women?
Difficulty in Interpreting the Literature

What is meant by “psychotherapy”?
WHO, WHAT, WHERE and WHY?

**Who** delivers?
- Peer
- Nurse
- Psychotherapist

**Where?**
- Home
- School
- Church
- Clinic
- Private practice

**What type?**
- Nondirective counseling
- Psychoeducation
- Cognitive Behavioral
- Interpersonal
- Psychodynamic

**Why?**
- “At risk” populations
- Mild vs. Moderate MDD
## Meta-Analysis of Psychotherapy in Perinatal Depression

<table>
<thead>
<tr>
<th>Author</th>
<th>Study Populations</th>
<th>Types of Studies included</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cuijpers, et al. (2008)&lt;sup&gt;1&lt;/sup&gt;</td>
<td>Postpartum only</td>
<td>Controlled</td>
<td>Moderate Effect d=0.61 (95% CI: 0.37-0.85)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>17 total</td>
<td></td>
</tr>
<tr>
<td>Dennis, et al. (2009)&lt;sup&gt;2&lt;/sup&gt;</td>
<td>Postpartum only</td>
<td>Controlled</td>
<td>Moderate Effect RR=0.75 (95% CI: 0.63-0.88)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>10 total</td>
<td></td>
</tr>
<tr>
<td>Sockol, et al. (2011)&lt;sup&gt;3&lt;/sup&gt;</td>
<td>Antenatal and postpartum</td>
<td>Controlled and open</td>
<td>Moderate Effect g=.65 (95% CI: 0.45-0.86)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>27 total</td>
<td></td>
</tr>
<tr>
<td>Claridge (2012)&lt;sup&gt;4&lt;/sup&gt;</td>
<td>Antenatal and postpartum</td>
<td>Controlled and open</td>
<td>Large- Moderate Effect d=1.14 one group d=0.4 control groups</td>
</tr>
<tr>
<td></td>
<td></td>
<td>24 total</td>
<td></td>
</tr>
</tbody>
</table>

Meta-Analysis of Psychotherapy in General Population

<table>
<thead>
<tr>
<th>Therapy</th>
<th>Treatment Focus</th>
<th>Methods</th>
<th>Effect Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supportive²</td>
<td>Coping skills and defenses</td>
<td>Problem solving</td>
<td>d=0.58</td>
</tr>
<tr>
<td></td>
<td>Consciousness, conflicts/problems</td>
<td>Emotional support</td>
<td>(95% CI: .45-.72)</td>
</tr>
<tr>
<td>CBT³</td>
<td>Cognitions/Automatic thoughts</td>
<td>Thought records</td>
<td>d=.67</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(95% CI 0.60–0.75)</td>
<td></td>
</tr>
<tr>
<td>IPT⁴</td>
<td>Interpersonal relationships</td>
<td>Communication analysis</td>
<td>d=0.63</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Role playing</td>
<td>(95% CI: .36-.90)</td>
</tr>
<tr>
<td>Brief Psycho-dynamic⁵</td>
<td>Unconscious emotions, conflicts, defenses</td>
<td>Exploration, uncovering,</td>
<td>d=0.69</td>
</tr>
<tr>
<td></td>
<td></td>
<td>interpretation, Transference</td>
<td>(95% CI: 0.30–1.08),</td>
</tr>
</tbody>
</table>

The efficacy of psychotherapy for depressed perinatal patients is comparable to that for depressed patients in the general population.

Psychotherapy for Perinatal Mood Disorders: Review of Specific Therapies
Interpersonal Psychotherapy for Perinatal Depression

• Time limited (12-24 weeks)
• Informed by attachment theory/psychodynamic theory
• Focus on:
  • Role Transitions
  • Interpersonal Role Disputes
  • Grief and Loss

Clinical Characteristics of Postpartum Women with Unipolar Major Depression

Prevalence of Interpersonal Stressors:

- Marital problems 43.1%
- Work stress 31.3%
- In-law problems 20.6%
- Recent move 16.9%
- Given high prevalence of interpersonal stressors, IPT may be well suited to treatment of perinatal depression

- Study population: N=75
  - Inclusion Criteria: DSM IV R unipolar MDD

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## Interpersonal Psychotherapy for Perinatal Depression

<table>
<thead>
<tr>
<th>Author</th>
<th>N</th>
<th>Design</th>
<th>Results</th>
</tr>
</thead>
</table>
| Ohara, et al. (2000)¹   | 99 | Postpartum RCT 12 week IPT vs. Wait List Control | Significant improvement:  
Response: 43.8% vs. 13.7% p=.001  
Remission: 37.5% vs. 13.7% p=.007 |
| Spinelli and Endicott (2003)² | 50 | Antenatal RCT 16 weeks IPT vs. Parent Education | Significant improvement:  
Response: 52.4% vs. 29.4% p=.002  
Remission: 60.0% vs. 15.4% p=.02 |
| Grote, et al. (2009)³   | 53 | Antenatal RCT 8 weeks with monthly follow-up (E IPT-B) vs. enhanced usual care (E UC) | Significant improvement:  
Response: 80% vs. 29% p<.001  
Remission: 95% vs. 58% p<.003 |
| Pearlstein et al. (2006) | 23 | Postpartum: Patients selected either IPT alone  
Medication alone  
IPT + Sertraline (titrated to max of 150 mg/d)  
12 weeks | Significant clinical improvement in all treatment groups (p<.01) |

IPT Treatment Considerations

• “Poorer responders” or “nonresponders” to IPT in nonperinatal depressed patients:
  • Chronicity
  • Severity of depression
  • Comorbid anxiety disorders (panic, social phobia)
  • Comorbid substance abuse

IPT New Directions

Partner Assisted IPT\textsuperscript{1,2}:
- 8 week open trial
- Decreased depressive symptoms in women postpartum and improved “attunement” of partner to depressive symptoms

Pregnant Teen IPT (IPT-PA)\textsuperscript{3}
- 12 week open trial
- Decreased depressive symptoms by 50% and 40%

Group IPT\textsuperscript{4}
- 8 week randomized controlled trial
- Significantly greater improvement in depressive symptoms and perception of marriage in IPT-G vs. control
- IPT-G sustained improvement at 2 year follow up\textsuperscript{5}

CBT for Perinatal Depression

- CBT as effective in treatment of major depression in perinatal population as in nonperinatal major depression
- Adaptations effective
  - Culturally sensitive innovations (ex. Mamas y Bebes)
  - Internet based
- Increased efficacy associated with
  - Postpartum > antepartum
  - Individual > Group interventions but women express preference for group

(Sockol LE. *J Affective Dis*. 2015; 177: 7-21)
Supportive and Brief Psychodynamic Psychotherapy (BDT) in Perinatal Mood Disorders

- Supportive psychotherapy -- individual\(^1,2,3\), and group\(^4\) -- superior to wait list control or treatment as usual for treatment of depressive symptoms
- Brief psychodynamic therapy:
- Significant decrease in depression in one naturalistic\(^5\) and one RCT comparative study\(^6\)
- RCT with or without Sertraline\(^7\):
  - *No benefit with Sertraline added:*
    - Response/Remission: BDT + Sertraline 70%/65%
    - BDT + Placebo 55%/50%
    - \(p = .033/.034\)

# Psychotherapy for Prevention of Postpartum Depression

<table>
<thead>
<tr>
<th>Focus</th>
<th>Interpersonal Psychotherapy</th>
<th>Cognitive Behavioral</th>
<th>Psychoeducation</th>
<th>Infant Focused</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relationships</td>
<td>Relationships</td>
<td>Negative cognitions</td>
<td>Information</td>
<td>Infant behavior</td>
</tr>
<tr>
<td>Role transition</td>
<td>Role play</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intervention Techniques</td>
<td>Role play</td>
<td>Cognitive restructuring</td>
<td>Baby care</td>
<td>Information on infant sleep and crying</td>
</tr>
<tr>
<td></td>
<td>Communication skills</td>
<td>Behavioral activation</td>
<td>Maternal physical care</td>
<td>Settling and feeding information</td>
</tr>
<tr>
<td></td>
<td>Problem solving</td>
<td></td>
<td>Depression information</td>
<td></td>
</tr>
</tbody>
</table>

**Results**

- Significant difference between IPT and Control group in risk of PPD in 4/7 RCT
- Significant difference between CBT and control in 4/6 Group less effective
- Significantly decreased depressive symptoms in intervention group

Werner E. Et al. *Arch Womens Ment Health* 2015; 18: 41-60; Dennis CL and Dowswell T. *Cochrane Database Rev.* 2013)
Challengers to the Perinatal Psychotherapy “Frame”

- Cultural factors
- Health care availability
- Child care issues
Cultural factors:
  ➢ Ethnographic interviewing¹

Health care availability/delivery factors:
  ➢ Peer support²
  ➢ Telephone support³ or therapy⁴

Child care issues:
  ➢ Baby-friendly office environment
  ➢ Telephone support³
  ➢ Flexible therapy schedule

The Challenge of Applying Evidence Based Psychotherapy in the Perinatal Population

Pare, Ambrose. Medical Illus. from *Les Ouvres de M. Ambrose Pare.* (Paris: Gabriel Buon, 1575) 810. Courtesy of History of Medicine Division, U.S. National Library of Medicine, NIH.
Can these studies be generalized? Do they translate to clinical practice?

Most psychotherapy studies:
- Short duration (<16 weeks)
- Exclude comorbid Axis I and II disorders
- Exclude suicidal patients
- Mild-moderate depression (Beck Depression Inventory < 30; Hamilton Depression Scale < 19)

Postpartum Depression at Stanford:

37% Suicidal Ideation
“The Difficult Patient”: Suicidal Ideation

- Wide range of rates of SI, depending on populations of studies
- Increased risk in women
  - Not in treatment
  - Younger maternal age
  - Unpartnered status
  - Unplanned pregnancy
- Intimate partner violence and history of childhood abuse

Fig. 2
The stress–diathesis model of antepartum suicidal ideation and behavior

## “The Difficult Patient”: Personality Disorders Prevalence of Personality Disorders in Patients with PPD

<table>
<thead>
<tr>
<th>Author</th>
<th>Measure(s)</th>
<th>N</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Akman et al 2007&lt;sup&gt;1&lt;/sup&gt;</td>
<td>SCID</td>
<td>302</td>
<td>Avoidant: 26.3% vs. 4.6% p=.003</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Obsessive Compulsive: 31.6% vs. 1.4% p=.000</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Dependent: 21.1% vs. 1.8% p=.001</td>
</tr>
<tr>
<td>Apter et al 2012&lt;sup&gt;2&lt;/sup&gt;</td>
<td>MADRS SIDP-V</td>
<td>109</td>
<td>BPD: 44% vs. 11% p=.0002</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Paranoid 26% vs. 7% p=.009</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Avoidant 18% vs. 4% p=.024</td>
</tr>
</tbody>
</table>


“The Difficult Patient:” Borderline Personality Disorder

• DSM V Criteria: Pervasive pattern of instability of interpersonal relationships, self image, and affects and marked impulsivity, beginning in adulthood and present in a variety of contexts

• > 5 of the following:
  › Frantic efforts to avoid real or imagined abandonment
  › Pattern of unstable and intense interpersonal relationships characterized by alternating extremes of idealization and devaluation
  › Identity disturbance: markedly and persistently unstable self-image or sense of self
  › Impulsivity in at least two areas that are potentially self damaging
  › Recurrent suicidal behavior, gestures, threats, self mutilation
  › Affective instability due to marked mood reactivity
  › Chronic feelings of emptiness
  › Inappropriate, intense anger or difficulty controlling anger
  › Transient, stress related paranoid ideation or severe dissociative symptoms
“The Difficult Patient”: Borderline Personality Disorder

• Little research to date regarding prevalence, pregnancy outcome or treatments
• Potential clinical issues
  • Splitting leading to poor treatment compliance
  • Poor boundaries with staff
  • Somatization/symptom amplification in order to increase access to idealized providers/avoid imagined abandonment
• Demanding early delivery due to fears of birth trauma1

1Blankley C. et al. 2015; Australas Psych. 23: 688-692.
Perinatal Psychotherapy Challenges: Trauma

- Trauma history increases risk of PPD\(^1\)
- Prevalence of new onset PTSD in women with traumatic childbirths range estimated 2% but 40% subsyndromal\(^2\)
- Treatment recommendations
  - Debriefing has not been shown to prevent birth related PTSD in limited studies completed to date\(^3\)
  - Trauma focused CBT
  - ? EMDR

\(^3\)Bastos MH et al. *Cochrane Database Syst Rev.* 2015; 10:
Case Example

• Ms. G. is a 40 year old MF G2P1 who presents at 28 weeks IUP. Her pregnancy is currently progressing without complications except increasing anxiety. She says that the pregnancy was planned and very much desired, but that it had been postponed for over a decade because of fear of childbirth. Her first child is now 25 years old, and she says that at the time of her birth she had had an emergency C section because of fetal distress. She says that she had entered the hospital emergently because her water broke after a fall outside her obstetrician’s office at her 38th week OBGYN visit. She says she had cramping and bleeding and when she was being admitted for monitoring, it was found that baby was experiencing prolonged decelerations. She was unable to reach her husband or other family members and remembers her “terror” when she was wheeled into the operating room. While the baby was born safe, Ms. G. had persistent re-experiencing events of being wheeled into the operating room, her heart racing and fearing that she and her baby would die. She said she could feel the stirrups on her legs and felt like she was being strapped down against her will. She said that for many years she had avoided going near obstetrical units—she did not visit her sister in the hospital after she had a baby. Ms. G. reported that these symptoms had improved over the ensuing years without treatment, but that in the past few weeks, as her due date approached, she was experiencing increased anxiety, fearing that these symptoms would recur. She still had not returned to a labor and delivery room since her birth, and continued to have trouble with lithotomy positions.
The “Difficult Patient”: Recommendations for Patients with a History of Trauma (Both Perinatal and Nonperinatal)

- High index of suspicion in patients who request an elective C-section or who have extremely rigid birth plan or who have vaginismus and difficulty with physical exams (especially pelvic).
- Review their current birth plan at length and provide reassurance that they will be given as much control as possible.
- Encourage a ‘team approach:’ explain to them that their birth plan will be shared with all staff with their permission, and encourage them to include important family members as well.
- If possible, consistent staff members and explicit explanations ahead of time of procedures and plans.

2 Weitlauf et al. *J Women’s Health.* 2008; 112: 1343-50
Prevention of Traumatic Stress in Mothers of Preterm Infants

“The Difficult Patient”: Perinatal OCD

- Women with previous OCD have high rates of postpartum depression and postpartum OCD exacerbation\(^1\)
- New onset of obsessions without compulsions is common\(^2,3\)
- No RCT to date of psychotherapy for perinatal OCD, but case series show improvement\(^4\)
- Obsessional thoughts of infant harm common in postpartum depression\(^5\)

From: Onset Timing, Thoughts of Self-harm, and Diagnoses in Postpartum Women With Screen-Positive Depression Findings


Table 2. Primary and Secondary Diagnoses in Postpartum Women With EPDS Score of 10 or Higher

<table>
<thead>
<tr>
<th>Primary Diagnoses (826 Home Visits)</th>
<th>No. (%)</th>
<th>Secondary Diagnoses for Primary Diagnostic Category</th>
<th>No. (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unipolar depressive disorders</td>
<td>566 (66.5)</td>
<td>Secondary diagnoses in 374 women with primary depressive disorders</td>
<td>516 (62.5)</td>
</tr>
<tr>
<td>Major depression</td>
<td></td>
<td>Anxiety disorders</td>
<td>428 (52.9)</td>
</tr>
<tr>
<td>Recurrent</td>
<td>368 (45.0)</td>
<td>Generalized anxiety</td>
<td>224 (52.3)</td>
</tr>
<tr>
<td>Single episode</td>
<td>146 (25.6)</td>
<td>Panic</td>
<td>59 (13.6)</td>
</tr>
<tr>
<td>Depressive disorder NOS</td>
<td>38 (6.7)</td>
<td>Social phobia</td>
<td>53 (12.4)</td>
</tr>
<tr>
<td>Adjustment disorder with depressed mood</td>
<td>11 (1.9)</td>
<td>Obsessive-compulsive</td>
<td>47 (11.0)</td>
</tr>
<tr>
<td>Major disorder NOS</td>
<td>2 (0.4)</td>
<td>Posttraumatic stress</td>
<td>45 (10.5)</td>
</tr>
<tr>
<td>Dysthymic disorder</td>
<td>1 (0.2)</td>
<td>Substance use disorders</td>
<td>61 (11.8)</td>
</tr>
<tr>
<td>Bipolar disorders</td>
<td>187 (22.9)</td>
<td>Secondary diagnoses in 136 women with primary bipolar disorder</td>
<td>223 (27.0)</td>
</tr>
<tr>
<td>Bipolar II</td>
<td>58 (31.0)</td>
<td>Anxiety disorders</td>
<td>159 (84.8)</td>
</tr>
<tr>
<td>Bipolar I-depressed</td>
<td>54 (20.9)</td>
<td>Generalized anxiety</td>
<td>72 (30.1)</td>
</tr>
<tr>
<td>Bipolar NOS</td>
<td>35 (18.7)</td>
<td>Panic</td>
<td>50 (26.5)</td>
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<tr>
<td>Bipolar I-mixed episode</td>
<td>32 (17.1)</td>
<td>Posttraumatic stress</td>
<td>34 (19.0)</td>
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<tr>
<td>Bipolar I-manic episode</td>
<td>7 (3.7)</td>
<td>Obsessive-compulsive</td>
<td>33 (17.5)</td>
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<tr>
<td>Schizoaffective disorder</td>
<td>1 (0.5)</td>
<td>Substance use disorders</td>
<td>27 (12.1)</td>
</tr>
<tr>
<td>Anxiety disorders</td>
<td>45 (5.6)</td>
<td>Secondary diagnoses in 24 women with primary anxiety disorders</td>
<td>46 (5.6)</td>
</tr>
<tr>
<td>Generalized anxiety disorders</td>
<td>24 (52.2)</td>
<td>Depressive disorders</td>
<td>23 (50.0)</td>
</tr>
<tr>
<td>Obsessive-compulsive disorder</td>
<td>8 (17.4)</td>
<td>Major depression, recurrent</td>
<td>12 (52.2)</td>
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<tr>
<td>Anxiety disorder NOS</td>
<td>8 (17.4)</td>
<td>Major depression, single episode</td>
<td>6 (26.1)</td>
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<tr>
<td>Adjustment disorder with anxiety</td>
<td>3 (6.5)</td>
<td>Dysthymic disorder</td>
<td>5 (21.7)</td>
</tr>
<tr>
<td>Panic disorder without agoraphobia</td>
<td>1 (2.2)</td>
<td>Other anxiety disorders</td>
<td>15 (52.6)</td>
</tr>
<tr>
<td>Posttraumatic stress disorder</td>
<td>1 (2.2)</td>
<td>Substance use disorders</td>
<td>8 (17.4)</td>
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<tr>
<td>Specific phobia</td>
<td>1 (2.2)</td>
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<td></td>
</tr>
<tr>
<td>Substance use disorders</td>
<td>4 (0.5)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Substance-induced mood disorder</td>
<td>1 (25.0)</td>
<td></td>
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<tr>
<td>Alcohol abuse/dependence</td>
<td>1 (25.0)</td>
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<tr>
<td>Opioid abuse/dependence</td>
<td>1 (25.0)</td>
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<tr>
<td>Polysubstance dependence</td>
<td>1 (25.0)</td>
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<td>Other disorders</td>
<td>6 (0.7)</td>
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<tr>
<td>No diagnosis</td>
<td>17 (2.1)</td>
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</tbody>
</table>

Abbreviation: NOS, not otherwise specified.

*The number of secondary diagnoses does not match the number for a primary diagnosis group because some patients have no secondary diagnosis while others present with more than 1 secondary diagnosis. The percentages are the percentages of the total number of secondary diagnoses.
“The Difficult Patient”: Unrecognized Bipolar Disorder

- Always screen for bipolar disorder in women with PPD
  - In a prospective study of PPD in university clinic (N=56)
  - 54% Bipolar Disorder (BPI 7%, BPII 43%, BPNOS 36%)
    - Only 10% patients previously diagnosed bipolar
  - 46% Major Depression, unipolar
- Early onset of symptoms
  - 40% immediately after delivery
  - 20% two days postpartum
  - 20% three months postpartum
  
Sharma V. et al. *Bipolar Disorders* 2008; 10: 742-747

- High index of suspicion in “Treatment Resistant Depression”
  - Chart review of 60 patients
  - 57% re-diagnosed Bipolar

Summary: Recognizing Bipolar Disorder in the Postpartum Patient

• Clinical Clues
  • Symptom onset first month postpartum
  • Hypomania postpartum
  • Early age of onset of mood disorder
  • More frequent depressive episodes
  • Atypical or psychotic features
  • Family history of bipolar disorder
  • Previous history of induction of mania, mixed episode or rapid cycling after antidepressant trial
  • More frequent episodes of shorter duration
  • Seasonality

“The Difficult Patient:” Postpartum Thyroiditis

- Postpartum Thyroiditis
  - 4.9-5.4% of pregnant women
  - Autoimmune condition with high titers of antimicrosomal antibodies
  - Increased incidence in women with other autoimmune disorders
    ‣ DM Type I, SLE
  - High titers of antimicrosomal antibodies may be independently related to postpartum mood states (but prophylactic treatment with Levothyroxine did not decrease PPD rates in PC study)
    ‣ Stagarno-Green A. *J Clin Endocrinol Metab.* 2012; 97: 334-342
Postpartum Thyroiditis
Asymptomatic no treatment

Symptomatic (palpitations, fatigue, heat intolerance, nervousness)
Treat-starting dose of propranolol 10-20 mg qid

Repeat TSH in 4-6 weeks or if becomes symptomatic

Euthyroid

Repeat TSH every 2 months until 1 year postpartum

Hypothyroid phase

Treat with levothyroxine

- Symptomatic
- Attempting pregnancy
- Breast feeding
- TSH elevation exceeds 6 month

- Continue treatment until 6-12 months after initiation of levothyroxine
- Attempt weaning trial by halving the dose and repeating TSH in 6-8 weeks.
- Do not attempt weaning if patient is pregnant, breast feeding or attempting to conceive

Do not treat

- Asymptomatic
- Duration of hypothyroidism less than 6 months

Yearly TSH measurement in women who had PPT and returned to the euthyroid state

Stagarno-Green A. J Clin Endocrinol Metab. 2012; 97: 334-342
Other Medical Differential Diagnosis to Remember:

- **Vitamin D deficiency**

- **Anemia**
Perinatal Psychotherapy: Translating Research into Clinical Practice

Perinatal Depression

- Interpersonal Distress
  - IPT
    - IPT-P Marital Therapy
  - Brief Dynamic
  - Obsessions Panic Attacks
    - CBT Mindfulness

Trauma
  - CBT, Exposure Therapy

Borderline Personality
  - DBT
    - Psychodynamic
Directions for Future Research

• Psychotherapy for women with perinatal mood disorders complicated by:
  • Personality disorders
  • Trauma
  • Dual diagnosis
  • Bipolar disorder
• Efficacy of newer brief therapies, including Acceptance and Commitment Therapy (ACT), Emotion Focused (EMT), Dialectical Behavior (DBT) and Mother Infant Therapies
• Comparison of response rates: antidepressants vs. psychotherapy or adjunctive treatments
Omega-3-Fatty Acids

- Omega-3-fatty acids have not been shown to prevent or acutely treat perinatal mood disorders
- Recommendation in nonperinatal mood disorder patients (APA Omega-3-Fatty Acids Subcommittee)
  - 1 g EPA plus DHA minimum
- **Recommended dose in pregnancy** (World Association Perinatal Medicine, Child Health Foundation, Early Nutrition Academy)
  - 200 mg DHA
  - Consider supplementing in mood disorder patients

Bright Light Therapy for Perinatal Mood Disorders

• Only two randomized “placebo” controlled in antenatal\(^1,2\) and one in postpartum depression\(^3\)
• Results mixed but sample sizes small
• Risk of hypomania/mania in patients with bipolar disorder
• Recommended protocol:
  • 10,000 lux for 30 min upon awakening

Conclusions

• Risk factors for Perinatal Mood Disorders are multifactorial and there is an increased appreciation for the history of trauma, (childhood, intimate partner abuse and perinatal complications) and attachment style and personality factors.

• Do not forget to “widen the differential diagnosis” in “The Difficult Patient” and rule out other psychiatric and medical conditions that need treatment.

• Psychotherapy for Perinatal Mood Disorders is evidence based.

• Treatment for women with perinatal mood disorders must include thorough assessment of personality, interpersonal and historical factors as all may complicate treatment.

• Other nonpharmacologic treatments to consider include bright light therapy and omega three fatty acids.