

Maternal Mental Health for General Psychiatry

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No Disclosures

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Maternal Mental Health

- Discuss symptoms of depression in pregnancy & the postpartum
- Describe presentation of Postpartum Psychosis (PPP), & consider risk assessments in PPP
- Describe issues for consideration in prescribing medication in pregnancy & the postpartum, including when evaluating the capacity to refuse treatment

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Outline: Pregnancy

- Major principles of psychiatric treatment in pregnancy
- Risks of untreated illness vs. risks of medications
 - Examples
 - Absolute vs. relative risks
- Consideration of Malpractice in psychiatric treatment in pregnancy

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Why is this important?

- Mental illness often strikes during childbearing years
- Higher rates of high-risk sexual activity
- Lower rates of contraceptive use
- Higher rates of unplanned pregnancy
- Don't miss the opportunity to discuss contraceptive planning...

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Antenatal Depression

- 10-20% of pregnant women
 - Two-fifths with depressive history will have episode in pregnancy
 - Two-thirds who discontinued their antidepressant will have episode in pregnancy
 - Greater risk of prematurity, fetal distress, neonatal behavior, & PPD
 - Approximately 1/3 of PPD cases actually began during pregnancy
- (Freeman, 2007; Howard et al, 2014)

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Treatment Planning

- FDA categories?
- Research literature?
- Clinical experience?
- Accident?



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Psychotropics in Pregnancy

- Health of Mother & Fetus
- Rights of Mother & Fetus
- Risks of Treating vs. Risks of Not Treating
- Ethics, Law & Best Interests

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Urgency?

- Symptoms
- Level of distress
- Impact on parenting

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Art or Science?

- Past response history
- Severity of symptoms
- Moving target with new information & often
- Mixed findings
- Infrequent exposure & outcomes
- Retrospective studies & confounders
- Principles of risk-benefit assessment

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Issues

- Risk of relapse during pregnancy high with medication discontinuation
- Non-pharmacologic therapy
- Dosing changes, target symptoms in pregnancy
- Lack of knowledge of response to alternative medications
- Frequent lack of planning of pregnancy

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More than
half of all
pregnancies are
unplanned.



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Psychotropic Exposure in Pregnancy

- First 2 weeks: utero-placental circulation not yet established
- 2-12 weeks: organogenesis



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Uncertainty of Risks of Psychotropic Medications Weighed with Baseline Rates of Malformation & Risks of Mental Illness

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- Risks of Treatment in Pregnancy
- Vs. Risks of NOT Treating in Pregnancy



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Table 2 Potential Risks of Medications in Pregnancy That Physicians Should Consider

Risks of Medication
Maternal risks
Fetal loss
Prematurity
Malformations
Neonatal syndromes (toxicity or withdrawal)
Neurobehavioral sequelae

(Friedman et al, 2018)

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Neonatal Withdrawal & Toxicity

- <48 hours of life → NICU
 - Poor adaptation
 - Jittery
 - Irritability
 - Poor gaze control
- (Hale, 2004)



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Table 1 Potential Risks of Not Treating Mental Illness in Pregnancy

Risks of Not Treating
Suicide
Unintentional self-harm
Infanticide/child abuse
Poor prenatal care, ability to care for self
Increased use of illicit substances
Increased risk of negative outcomes from mental illness, such as low birthweight and prematurity
Effects on bonding with baby

(Friedman et al, 2018)

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Potential Risks of Untreated Perinatal Mental Illness

- Suicide
- Child neglect or abuse due to active symptoms
- Infanticide – Psychotic or maltreatment-related
 - “Have you thought of what would happen to baby if you were to take your own life?”

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- There is no no-risk option
- Supporting patient in her decision-making

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Initial Structure to Evaluation

- Woman's & partner's expectations & concerns
- Knowledge of pregnancy physiology
- Knowledge of risk concepts
- Awareness of birth outcome information (birth defects 3%, no guarantee of normally formed or developing child)
- Understanding of disease & treatment exposure options

(Patel & Wisner, 2011)

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Individual Risk-Benefit

- Consider mother & baby as dyad
- Good understanding of literature & concepts
- Good history: dx, past meds
- Current functioning
- Other exposures whilst pregnant
- Obstetrical history

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Treatment

- Evidence-based treatment
- Individualized
- Non-drug interventions
- Document the woman's partner's questions/decision
- Confer with obstetrician/midwife/ GP/ Pediatrics

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Different Psychiatric treatment goals in pregnancy: Management of symptoms vs. Remission

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Antidepressants in Pregnancy

- Most data do not suggest increased risk of either miscarriage or malformation
- Maternal SSRI in 2nd half of pregnancy associated with persistent pulmonary hypertension of newborn
- May increase risk of prematurity (Suri, 2007)

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December 2011 FDA

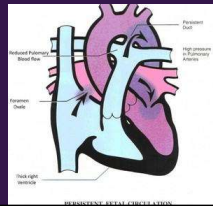
12/16/11: "There have been conflicting findings from new studies evaluating this potential risk, making it unclear whether use of SSRIs during pregnancy can cause PPHN."



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PPHN

- Persistent fetal circulation
- Life-threatening: 15% mortality
- Risk factors: Smoking, Obesity, Diabetes, NSAIDs, Meconium aspiration
- Absolute risk vs. relative risk
 - General risk 2/1000
 - Increased to 3/1000 with SSRI



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Psychosis in Pregnancy

- No significant hyperprolactinemia (except Risperidone)
- Difficulty planning pregnancy
- Data from teratogen information services & manufacturer databases
- Risk-Benefit analysis

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Ethics in Reproductive Psychiatry

- Errors of Omission vs. Commission errors
- Beneficence (patient's best interest) vs. Relational ethics (baby & mother outcome)
- Autonomy (enhancement by education)
- Preventative ethics (in tx of women of child-bearing age)

(Miller, 2009; Friedman, 2015)

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Act of Commission
vs.
Act of Omission

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Non-Maleficence: Omission vs. Commission

- Doctors more concerned about errors of commission
- Leads to failure to treat mental illness
- Other than pregnant women, when else do psychiatrists avoid treating mental illness?
- Risk of exacerbation, suicide/homicide

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Beneficence (Best Interests)

"The patient's well-being and her baby's well-being are intertwined rather than at odds"
(Miller, 2009)



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Autonomy

- Increase by fully explaining risk
- Absolute rather than relative risk
- Throughout course of treatment
- People often overestimate risk based on individual (N=1) experiences



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Preventative Ethics

- Anticipate in advance
- Discuss pregnancy, meds, illness in advance
- Discuss both mother & baby well-being, not merely baby!

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Table 3 Suggestions for Completion of Evaluation for Involuntary Treatment in Pregnancy

Points to be Included in Evaluation
Start with standard forensic approach for forced treatment
Know the law in your jurisdiction (<i>Rennie or Rogers model</i>)
Diagnosis
Rationale for need for treatment
Reason capacity is lacking
Determining less restrictive alternatives
Knowledge of literature on fetal and pregnancy complications (harm to woman's body or breach of fetal rights)
Clearly identify harms of no treatment in report more than usual; others may focus only on medication harms or may be ignorant of the risks of not treating
Communication with other medical staff (e.g. obstetrics and pediatrics), since risk is outside usual area of forensic expertise
Clearly understand trimesters (e.g., the point at which the fetus becomes viable, the medications that may pose a risk during different trimesters/weeks, and the length of time bed-rest needed)

(Friedman et al, 2018)

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Fear?

- Confusion in literature
- Lack of knowledge
- FDA warnings
- Autism fears
- Fear of lawsuits



→ worse care for vulnerable population

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Malpractice Risk (Pregnancy & Postpartum)

- Failure to treat
- Patient Abandonment
- Informed consent failure
- Bad Outcomes...



(Friedman & Hall, 2021)

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Bottom Line: What to do?

- Consider pregnancy possibility in women of reproductive age
- Communicate with patient, partner, OB
- Individual risk-benefit assessment with individual patient's history & tolerance
- Nothing Knee-jerk
- Consult when needed
- Document

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Conclusions: Pregnancy

- Risk-benefit considerations
- Principles of treatment in pregnancy
- Not just FDA letter
- Persistent Pulmonary Hypertension of Newborn & Ebstein's Anomaly: Absolute vs. Relative risk
- Malpractice considerations

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Postpartum Mental Illness

- Highest risk of mental illness is in postpartum year
- Suicide is the cause of 20% of postpartum deaths
- PPD 10-20%, peaks at 12 weeks
- PPP 1-2/1000
- Anxiety comorbidity common

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Postpartum Depression

- Depression in the peripartum: screening & diagnosing
- Differential diagnosis of PPD
- Treatment options in lactation & postpartum
- Risk-benefit analysis

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Perinatal Mental Health

- Often do not proactively seek help for their own needs, rather focused on baby
- May be unable to see a psychiatrist in community due to barriers to care such as insurance, stigma, & wanting to spend their available time in the NICU with their infants

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Symptoms of PPD

- Depressed mood
- Lack of enjoyment
- Sleep changes
- Appetite changes
- Energy/motivation ↓
- Concentration ↓
- Suicidal thoughts



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Mothers with Postpartum Depression...

- More withdrawn, disengaged, display more hostility & more likely to have disrupted attachment with their babies
- Less likely to employ healthy child development practices & to breastfeed
- Risk factor for child & adolescent psychopathology (including violent behaviors, depressive disorders and substance abuse)
- Untreated depression may lead to maternal psychotic symptoms, suicide, or homicide

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Risk Factors for PPD

- Social: IPV/abuse, negative events, ↓ social support, relationship issues, SES
- Psychological: anxiety/depression in pregnancy, history/FHx, substance misuse
- Biological: medical illness, multiple births, LBW/prematurity

(Howard et al, 2014)

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Edinburgh Postnatal Depression Scale

EDINBURGH POSTNATAL DEPRESSION SCALE (EPDS)
Please check the answer that comes closest to how you have felt in the PAST 7 DAYS, not just how you feel today in the past 7 days...

1. I have been able to laugh and see the funny side of things	☐ As much as I always could	☐ Not quite so much now	☐ Definitely not so much now	☐ Not at all
2. I have looked forward with enjoyment to things	☐ As much as I ever did	☐ Rather less than I used to	☐ Definitely less than I used to	☐ Hardly at all
3. I have blamed myself unnecessarily when things went wrong	☐ Yes, most of the time	☐ Yes, some of the time	☐ Not very often	☐ No, never
4. I have been anxious or worried for no good reason	☐ Yes, not at all	☐ Hardly ever	☐ Yes, sometimes	☐ Yes, very often
5. I have felt scared or panicky for no very good reason	☐ Yes, quite a lot	☐ Yes, sometimes	☐ No, not much	☐ No, not at all
6. Things have been getting on top of me	☐ Yes, most of the time I have not been able to cope at all	☐ Yes, sometimes I have not been coping as well as usual	☐ No, most of the time I have coped quite well	☐ No, I have been coping as well as ever
7. I have been so unhappy that I have had difficulty sleeping	☐ Yes, most of the time	☐ Yes, sometimes	☐ Not very often	☐ No, not at all
8. I have felt sad or miserable	☐ Yes, most of the time	☐ Yes, quite often	☐ Not very often	☐ No, not at all
9. I have been so unhappy that I have been crying	☐ Yes, most of the time	☐ Yes, quite often	☐ Only occasionally	☐ No, never
10. The thought of harming myself has occurred to me	☐ Yes, quite often	☐ Sometimes	☐ Hardly ever	☐ Never

Score Previous Scores 23/10/2010 18/11/2010

© Cox JL, Holden JM, and Sagovsky R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. British Journal of Psychiatry 150:782-786.

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Realistic Screening for PPD

- Edinburgh Postnatal Depression Scale
 - Cutoff score 10 - 12
 - Look at #10!
- Screening at Pediatrics & OB. Mother more likely to attend Peds appointment than her own follow-up
- Need identified referral resources in community or through Obstetrics or Family Practice

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Asking about PPD

- Diagnosis difficult because of body changes in postpartum
- 'Able to sleep when the baby sleeps?'
- Weight/appetite change different than expected
- Make sure to also ask about anxiety symptoms
- Ask about suicide, homicide & support from family/friends

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Depression Diagnosis

- Occurring for 2+ weeks
- Peak onset age 25-45
- Mean episode length 8 months
- Approximately 7% annual prevalence
- Increased in women, 10-25% lifetime

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Risk Factors for PPD

- Social: IPV/abuse, negative events, ↓ social support, relationship issues, SES
- Psychological: anxiety/depression in pregnancy, history/FHx, substance misuse
- Biological: medical illness, multiple births, LBW/prematurity

(Howard et al, 2014)

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Treatment Considerations for PPD

- Importance of Sleep
- Ask about lactation
- Medication
- Psychotherapy
- Support for childcare
- Family Meetings
- +/- Child Protective Services

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Non-Pharmacological Therapy

- CBT: Cognitive Behavioral Therapy
- IPT: Interpersonal Psychotherapy
- Family Therapy
- Psychodynamic psychotherapy
- Supportive psychotherapy

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Treatment Plans

- Non-pharmacological therapy may be first line for mild-moderate symptoms
- Close follow-up
- Careful medication history: past response
- ECT remains possibility

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Most Vulnerable

- Premature infants
- Neonatal disease
- Metabolic issues, hepatic, renal, cardiac or neuro issues
- First two months of life

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Lactation Exposure

- Infant dose per kg of <10% maternal dose per kg considered negligible
- Low relative dose: sertraline, paroxetine, bupropion, mirtazapine
- 10%(+) for citalopram, fluoxetine, venlafaxine

(Howard et al, 2014)

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Differential Diagnosis of PPD

- Baby Blues
- Postpartum Psychosis
- Postpartum Anxiety/PTSD
- Medical causes
- Substance use disorder
- PPD in Bipolar disorder

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DDx: Baby Blues

- Not synonymous with PPD
- 50-80% of new mothers
- Emotional sensitivity, mood lability, irritability
- Usually occurs within 5 days, resolves by second week postpartum
- Self-limited

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Risk of Misdiagnosis of Bipolar

- Treatment with un-opposed antidepressant agent
- Increased risk of inducing mania
- Increased risk of rapid cycling bipolar disorder



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PPD: Medical Mimics

- R/o Anemia
- R/o Thyroid disease
- R/o Hypoactive delirium
- R/o Infections
- R/o Alcohol/Substance Use disorder

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Postpartum OCD

- Commonly co-morbid with PPD
- Ego-dystonic intrusive thoughts
- May have intense distress that she is going to harm the infant
- May start avoiding holding baby for concern

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Postpartum PTSD

- Traumatic event experienced in birthing process (e.g. Emergency C-section)
- Avoiding the infant & hospital (triggers)
- Re-experiencing of trauma
- Easily startled
- Irritable, disconnected
- Early parental PTSD symptoms predict sleep & eating problems in childhood, & less sensitive / more controlling maternal behaviors
- Associated with less favorable toddler sleep @ 2y/o

(Garthus-Niegel et al, 2018)

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Maternal Depression & Parenting



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Mothers with Postpartum Depression...

- more withdrawn, disengaged, display more hostility & more likely to have disrupted attachment with their babies
- less likely to employ healthy child development practices & to breastfeed
- untreated depression may lead to psychotic symptoms, suicide or homicide
- ↓ self-care, substance misuse risk
- Paternal PPD in 10% fathers too (moderate correlation with maternal PPD)

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PPD & Potential Risks

- Impaired bonding
 - Attachment disturbance
 - Language development
 - Cognitive skills
 - Behavior problems
- (Friedman & Resnick, 2009)

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Potential Risks of Untreated PPD

- Child neglect or abuse due to active symptoms
- Suicide
- Infanticide – Psychotic or maltreatment-related
 - “Have you thought of what would happen to baby if you were to take your own life?”

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Suicide Risk in Peripartum

- Lower risk than in general female population but = 20% of peripartum deaths
- Overdose most common method
- Uncommon & dramatic methods more common in this population
- Teens & stigmatized single women at greater risk

(Lindahl et al, 2005; Samandar et al, 2011)

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Postpartum Depression and Infanticidal Thoughts

- 41% of depressed mothers of infants/ toddlers reported thoughts of harming their child

(Jennings et al, 1999)

- Psychiatrists often do not ask depressed mothers re: filicidal thoughts

(Friedman et al, 2008)

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Individual Risk-Benefit Analysis



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Lactation

- Monotherapy
- Lowest effective dose
- Collaboration with Pediatrician
- Infant toxicity
 - Hydration
 - Sedation
 - PO intake
 - Weight gain
- Not just labs

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Lactation

- Versus Bottle-feeding
 - Known benefits of lactation
 - Potential for additional maternal sleep if partner helpful
 - Lack of concern of medications' effect on baby

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General Antidepressant Considerations in Lactation

- Sertraline & paroxetine usually preferred SSRIs... (but paroxetine is generally not used in future pregnancies)
- However, fluoxetine or citalopram depending on response history/use in pregnancy
- Other meds in individual special cases

(Ram & Gandotra, 2015)

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Benzodiazepines in Lactation

- Short-term low-dose benzos generally considered safe
- Case reports of transient sedation
- Shorter acting favored (e.g. lorazepam)
- Minimum dose needed; infant monitoring

(Ram & Gandotra, 2015)

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Postpartum Psychosis (PPP) Prevalence

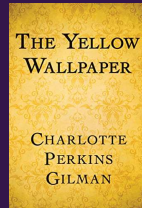
- 1-3/ 1000 deliveries
- Often in first 2 weeks after delivery, but can occur in later months
- Rapid onset & evolution



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History

- Hippocrates (400 BC)
 - acute onset of confusion, hallucinations, delirium & insomnia
- Marce (1800s)
- The Yellow Wallpaper (1899)



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Phenomenology

- Grandiose bizarre delusions
 - Paranoia
 - Mood lability
 - Hallucinations:
 - AH, VH, OH, TH
 - Confusion
 - Disorganized behavior
- (Friedman et al 2023)



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Phenomenology (2)

- Resembles delirium
- Resembles dysphoric mania
- As well as psychosis
- Abrupt onset
- Rapid evolution
- Most often correlated with Bipolar Disorder

(Friedman, Reed, & Ross, 2023)



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Differential Diagnosis

- Postpartum depression (10-20% of moms)
- Baby Blues (50-75% of moms)
- Schizophrenia
- OCD: reality testing (fears of PPP)
- Organic
 - Metabolic
 - Medication-induced or Substance-induced
 - Infectious
 - Cerebrovascular

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Why Postpartum?

- SLEEP DEPRIVATION!
- Increased stress!
- Mothering role stress
- Hormone shifts! (dec estrogen)
- Obstetrical complications
- Primiparous
- Socioeconomic status
- Trigger menstruation/ end lactation



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Table 1

Postpartum psychosis: Risk factors

Personal or family history of postpartum psychosis
Bipolar disorder or schizoaffective disorder
Hormonal shifts after birth (primarily rapid drop in estrogen)
Immune activation
Sleep deprivation in susceptible women
Primiparity

Source: Reference 2

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Table 2	Table 3
Medical differential diagnosis for postpartum psychosis	Laboratory testing and radiologic imaging
Infection (ie, endometritis or CNS infection)	Complete blood count
Primary hyperparathyroidism	Urinalysis
Thyroid disease	Comprehensive metabolic profile
Substance intoxication or withdrawal	Urine drug screen
Peripartum blood loss and anemia	Thyroid-stimulating hormone, free T4, and thyroid peroxidase antibodies
Tumor (primary or metastatic)	If neurologic symptoms are present: cerebrospinal fluid analysis, lumbar puncture, and antibody screening, serum ammonia concentration, EEG, and MRI
Autoimmune disease (anti-NMDAR encephalitis)	T4: thyroxine
Inborn errors of metabolism (urea cycle disorder)	Source: References 2,6,10-12
Head injury	
Ectopic	
Eclampsia	
Medication-induced (such as corticosteroids)	
Electrolyte anomalies	
Anoxia (Sheehan's syndrome)	
Vitamin B ₁₂ deficiency	
Anti-NMDAR: anti-N-methyl-D-aspartate receptor	
Source: References 2,6,10-12	

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Risks
• Suicide • Leading cause of death in first postpartum year • Neglect • Cognitive disorganization • Infanticide • 4% risk if untreated

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Risks
• Delusions (especially that Baby is evil or devil) • Homicidal thinking • Suicidal thoughts • Practical incompetence • Rapidly shifting symptoms → Risk

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Neonaticide

- The murder of the neonate by the parent in the first 24 hours of life.
- Some cases of neonaticide do involve psychotic mothers.

- Vs. Infanticide / Filicide
- Vs. Abuse/ Neglect

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Infanticide

- Often considered to include the murder of infants under one-year-old, at the hands of the parent.
 - (Filicide, more precisely, is the murder of a child by the parent.)
 - Psychiatric studies:
 - Psychosis,
 - Suicidality,
 - Depression.
 - Often, alcohol or substance use, limited social support, and a maternal history of abuse.
- (Friedman et al, 2026)

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Table 4

Infanticide motives: Not all are related to mental illness

Motive	Description	Relevance to PPP
Fatal maltreatment	The most common cause of Infanticide. Death as a result of abuse or neglect (often chronic)	Rarely related to PPP; but a mother with PPP may have inability or difficulty providing for the infant's needs
Unwanted child	Infant is unwanted due to inconvenience or future plans	Rarely related to PPP
Partner revenge	The least common cause of Infanticide. Murder of infant to cause suffering of other parent, may occur during custody battle	Rarely related to PPP
Altruistic	A mother with psychosis or depression kills her infant "out of love" believing that she is preventing earthly suffering; or a suicidal mother kills her infant and herself, rather than leave the infant in the world motherless	Often related to PPP or PPD
Acutely psychotic	A mother kills her infant for no comprehensible reason, such as in response to command hallucinations, or confusion in delirium	Often related to PPP

PPD: postpartum depression; PPP: postpartum psychosis
Source: Reference 27

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REGULAR ARTICLE

Obsessions of Child Murder:
Underrecognized Manifestations of
Obsessive-Compulsive Disorder

Bradley D. Booth, MD, Susan Hatters Friedman, MD, Susan Curry, BA(Hons),
Helen Ward, MD, and S. Evelyn Stewart, MD

Obsessive-compulsive disorder (OCD) is a common illness that remains underdiagnosed and undertreated. Distressing obsessions of violence are a frequent manifestation of OCD, related to overattribution of meaning to passing thoughts, a sense of overresponsibility, and concurrent confessing rituals to decrease related anxiety. These intrusive thoughts can include infanticidal or filicidal obsessions in new parents. There is little to no evidence to suggest that these thoughts pose a significant risk of harm, which is reflected in related professional treatment guidelines. In this study, we sought to examine the recognition and risk management preferences among psychiatry professionals and trainees regarding a case example description of filicide obsessions as a manifestation of OCD. A questionnaire regarding a case marked by filicide obsessions was emailed to psychiatrists and psychiatry residents. Respondents provided their preferred and differential diagnoses, reporting their perceptions of risk and optimal case management. Of the 43 respondents, only 42 percent considered OCD in the differential diagnosis. Those considering OCD in the differential diagnosis assessed risk of harm as being lower than did those who did not consider it ($D,7$ versus $E,6$; $F_{(1,34)} = 12.18$; $p < .005$). Despite this result, the majority of respondents included involuntary admission (60%) and reports to child welfare authorities (48%) among their preferred management strategies. This survey supports our contention that greater awareness of OCD and understanding of management strategies is needed among psychiatrists and trainees. As well, a greater awareness of the low risk of violence associated with this population is necessary to avoid penalizing individuals with OCD-related aggressive and infanticidal obsessions.

J Am Acad Psychiatry Law 42:64-74, 2014

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Psychiatric Emergency

- Risk of harming self
- Risk of harming others
- Rapidly evolving delusions, especially about infant
- Confusion around infant's care

- EMERGENCY HOSPITALIZATION?

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Table 1 Treatment for postpartum psychosis

Hospitalization	PPP is a psychiatric emergency requiring inpatient hospitalization. Mother-baby units, if available, are ideal options to maintain the dyadic relationship when safe.
Medications	Lithium remains the first line for prophylaxis and treatment of acute PPP. Antipsychotics and benzodiazepines are helpful as adjunct medications. Safety in breastfeeding should be discussed.
ECT	ECT is effective alone or as an augmentation to medication management for refractory cases.
Therapy	Importance of therapy for mothers, as well as psychoeducation for mothers and families.

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Treatment

- Treatment Alliance: mom & family/ support
- Psychoeducation: SLEEP
- Medication: Monotherapy goal
 - Mood Stabilizer
 - Atypical Antipsychotic
- Lactation?



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Table 5
Treatment plans for mothers with postpartum psychosis

Consideration	Comments
Suicide and infanticide risk assessment	Consider general risk factors as well as factors specific to the postpartum period. Also consider safety and risk of neglect. Notify Child Protective Services if appropriate based on risk assessment.
Evaluation	Rule out medical causes of presentation in the postpartum period.
Hospitalization	Psychiatric hospitalization rather than care at home is required in the vast majority of cases of PPP due to severity of symptoms and fluctuations. Develop a safe plan for infant while mother is hospitalized. Some locations have MSUs for psychiatric hospitalization (mothers with PPP may or may not meet criteria to be hospitalized together with their infant due to risk). Have supervised visits with infant when safe during hospitalization.
Psychoeducation	Educate patient and support network about diagnosis and risk. Discuss hospitalization: importance of managing sleep in a controlled environment, close monitoring and titration of psychiatric medications, observing warning and warning of symptoms. Psychoeducation about the illness and rationale for hospitalization may lead to voluntary rather than involuntary hospitalization.
Medication(s)	Mood stabilizer and/or antipsychotic. Avoid antidepressants, which may precipitate mixed state or rapid cycling. Consider the possibility of ECT. Consider maternal adverse effects (eg, sedation). Consider whether the mother is breastfeeding. Discuss with patient, family, and pediatrician when possible.

ECT: electroconvulsive therapy; MSU: mother-safety psychiatric units; PPP: postpartum psychosis

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Table 6
Safety after hospital discharge

Consideration	Comments
Child Protective Services notification	Based on risk assessment for the infant. CPS will review the case to determine a safety plan for the infant, which could include temporary custody or compulsory psychiatric follow-up.
Family meetings	Thorough discussion of diagnosis, risks, importance of medication compliance, importance of sleep, need for supports for infant care.
Outpatient appointments	Frequent outpatient appointments for follow-up with mother, with infant and partner present if possible.
Communication	Communication with obstetrics and pediatrics regarding risk and safety.
Home support	Support from family, visiting nurses, or childcare services are needed. The mother's sleep is critical.

CPS: Child Protective Services

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Screening

- Personal or family hx of PPP
- Edinburgh Postnatal Depression Scale
 - At 6 weeks postpartum visit
 - At well child visits
- Mood Disorder Questionnaire (MDQ)
- Not a specific screening test for PPP

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Prophylaxis

- Psychoeducation of at-risk mothers
 - Bipolar Disorder
 - Personal History
 - Family History
- Expectant management & monitoring
- Medication

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Recurrence Risk

- 14% for those with past PPP
- >50% for those with bipolar disorder or SAD/o
- Elevated for those who discontinue mood stabilizer vs. remain on mood stabilizers (70 vs. 24%)
- Family Hx

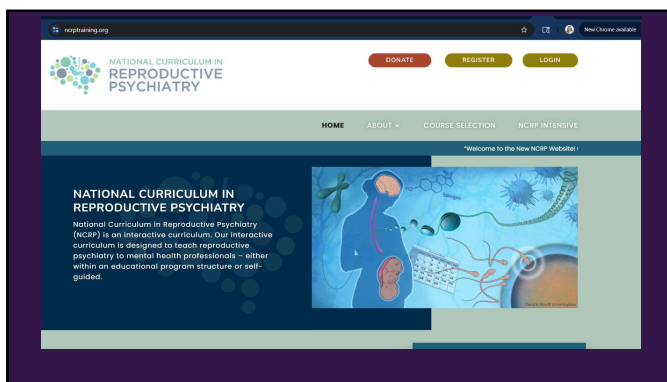
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Prevention

- Education of mom/ family/ community about symptoms to watch for
- Discussing risks with patient during/ before pregnancy
- ER/ MCT/ physician availability
- Prophylaxis

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Reproductive Psychiatry

- Importance of both identification & treatment during pregnancy & postpartum
- Anticipatory guidance
- Screening & diagnosis of PPD
- Especially critical to diagnose PPP & get rapid treatment
- Sleep & support are critical
- Consider whether breastfeeding
- The longer a medication has been in use, the more data in the perinatal population

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