

HOSPITAL PHYSICIAN®

PSYCHIATRY BOARD REVIEW MANUAL

PUBLISHING STAFF

PRESIDENT, PUBLISHER
Bruce M. White

EXECUTIVE EDITOR
Debra Dreger

SENIOR EDITOR
Becky Krumm, ELS

ASSISTANT EDITOR
Deidre Yoder

EDITORIAL ASSISTANT
Matthew T. Patton

SPECIAL PROGRAMS DIRECTOR
Barbara T. White, MBA

PRODUCTION MANAGER
Suzanne S. Banish

PRODUCTION ASSISTANTS
Tish Berchtold Klus
Christie Grams
Mary Beth Cunney

ADVERTISING/PROJECT MANAGER
Patricia Payne Castle

NOTE FROM THE PUBLISHER:

This publication has been developed without involvement of or review by the American Board of Psychiatry and Neurology.

 **Endorsed by the
Association for Hospital
Medical Education**

The Association for Hospital Medical Education endorses HOSPITAL PHYSICIAN for the purpose of presenting the latest developments in medical education as they affect residency programs and clinical hospital practice.

Peripartum Mood Disorders

Series Editor and Contributing Author: Jerald Kay, MD
Professor and Chair, Department of Psychiatry, Wright State University School of Medicine, Dayton, OH

Contributing Author: Deborah Y. Liggan, MD
Resident, Department of Family Practice, Bethesda Hospital, Inc., Cincinnati, OH

Table of Contents

| | |
|-----------------------------------------|-----------|
| Introduction | 2 |
| Case Presentation | 2 |
| Spectrum of Disorders | 2 |
| Diagnostic Approach | 4 |
| Pathophysiology | 5 |
| Treatment | 5 |
| Summary Points | 11 |
| Board Review Questions | 11 |
| Answers | 12 |
| References | 12 |

Cover Illustration by Vanessa Ray

Copyright 2000, Turner White Communications, Inc., 125 Strafford Avenue, Suite 220, Wayne, PA 19087-3391, www.turner-white.com. All rights reserved. No part of this publication may be reproduced, stored in a retrieval system, or transmitted in any form or by any means, mechanical, electronic, photocopying, recording, or otherwise, without the prior written permission of Turner White Communications, Inc. The editors are solely responsible for selecting content. Although the editors take great care to ensure accuracy, Turner White Communications, Inc., will not be liable for any errors of omission or inaccuracies in this publication. Opinions expressed are those of the authors and do not necessarily reflect those of Turner White Communications, Inc.

Peripartum Mood Disorders

I. INTRODUCTION

Pregnancy has been described as a time of emotional well-being during which many psychiatric disorders become quiescent. In truth, the reproductive years represent a time of enhanced vulnerability for the onset or reemergence of mood disorders that range from the minor, commonly occurring postpartum blues to manic episodes with severe psychotic symptoms. The erroneous belief that one should be happy about giving birth adds to the shame and stigma of mood disorders. Consequently, a pregnant woman or adolescent may be reticent to reveal her emotional pain for fear that disclosure will result in social isolation, a judgment that she is unfit to care for her child, or hospitalization.

There is overwhelming evidence that the biologic, psychologic, and psychosocial aspects of pregnancy exert a varied effect on mood disorders. During pregnancy, the placenta excretes estrogens and progesterone into the maternal system. With the removal of the placenta at delivery, estrogen and progesterone levels drop sharply, reaching pregravid levels by the fifth postpartum day. The impact of these hormonal changes on the course of mood disorders is unclear. However, growing clinical experience suggests that mood may be labile at the onset of pregnancy. For many patients who have either unipolar or bipolar disorder, the mood disorder stabilizes as the pregnancy advances but is followed by an increased postpartum risk for recurrence of the specific disorder. However, it is not uncommon for women to become symptomatic during the pregnancy.

Emotional experiences vary during the 3 trimesters of pregnancy, thus contributing to mood changes. A woman's feelings during the first trimester appear to be determined mainly by the physiologic changes that she is undergoing. During the last trimester, feelings are influenced by the approach-avoidance conflict regarding delivery. For the psychologically vulnerable patient, the stress of approaching delivery may be characterized by anxiety and increased emotional lability, tension, irritability, nightmares, depression, and insomnia.¹

More than 50% of females who have depression or mania never receive psychiatric attention, even though their contact with health services is greater around the

time of pregnancy and childbirth than at any other time. When mood disorders are not recognized or treated, parent health, parent-infant interaction, child development, and family stability may be seriously compromised. In extreme cases, untreated mood disorder may result in maternal suicide or infanticide.

II. CASE PRESENTATION

A 27-year-old pregnant mother of two is brought in to an appointment with a psychiatrist by her husband, who states that she has been increasingly irritable and impatient with the children. She becomes easily distracted when they ask her a question, and she no longer reads to the children at bedtime, an activity that had been a nightly ritual. The patient has been eating poorly, and she sleeps approximately 3 to 4 hours each night; sometimes she completes household chores and pays bills during the early hours of the morning. The patient's husband also notes that conversations have become increasingly one-sided. Often he cannot follow the discussion because his wife jumps from one topic to another. These symptoms have progressed over the past 5 to 6 days.

The patient is starting her second trimester of pregnancy. Her current medications are limited to prenatal vitamins. During her last pregnancy she was both mildly hypertensive and hyperglycemic, although that child was born without neonatal distress and weighed 7 lb, 11 oz.

The husband is concerned because his wife had one serious depressive episode at the age of 19 that required antidepressant therapy. Her symptoms at that time were sleeplessness, fatigue and lethargy, frequent crying spells, and weight loss (approximately 10 pounds over a 2-month period).

III. SPECTRUM OF DISORDERS

- **What diagnostic criteria differentiate the patient's symptoms from other affective disorders?**
- **How does pregnancy affect the course of mood disorders?**
- **What factors predispose a female to mood disorders during pregnancy or the postpartum period?**