Is It Depression or Something Else?

Navigating the Differential Diagnosis of Perinatal Mood and Anxiety Disorders

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Learning Objectives

- **By the end of this presentation, participants will be able to:**
  - Identify the key features of postpartum depression (PPD) and distinguish it from other perinatal mood disorders
  - Recognize the clinical presentations of perinatal anxiety, OCD, bipolar disorder, and postpartum psychosis
  - Understand to use the MDQ to screen for personal and family history of bipolar disorder
  - Identify red flags that require urgent referral or consultation
  - Describe first-line treatment approaches for common perinatal mood disorders

Why This Matters

- Perinatal period is **high risk** time
- **1 in 5** women will experience a perinatal mood or anxiety disorder (PMAD)
- PMADs are the **most common** complication of pregnancy and the postpartum period
- **75%** of women who screen positive for PPD **cannot access** timely treatment
- **Suicide and overdose** account for up to **20% of postpartum deaths** in women with depression
- Most PMADs go **undetected** — and PPD is only one piece of the puzzle

Why This Matters

Early identification and accurate diagnosis saves lives.

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Postpartum Depression (PPD)

What Is Postpartum Depression?

- Defined as a major depressive episode beginning **during pregnancy or within 4 weeks** of delivery per DSM-5 — but clinically recognized **up to 12 months postpartum**
- Affects approximately **15%** of postpartum women
- Up to **60%** of cases begin prenatally — often undetected
- Can present at time of weaning or with return of menses

What Is Postpartum Depression?

- **Core symptoms:**
  - Depressed mood, hopelessness, loss of interest or pleasure
  - Sleep and appetite changes, fatigue, poor concentration
  - Excessive guilt, feeling like a failure as a mother
  - Thoughts of self-harm or harming the baby (requires immediate assessment)

Baby Blues vs. PPD: Know the Difference

- **Baby Blues**
- Affects up to **85%** of women
- Onset **3-5 days** postpartum; resolves within **2 weeks**
- Tearfulness, mood lability, anxiety — but **not impairing**
- No treatment required — reassurance and support
- **Postpartum Depression**
- Affects **~15%** of women
- Onset within **weeks to months** postpartum
- **Functionally impairing** — affects parenting, relationships, self-care
- Requires clinical assessment and **treatment**

Baby Blues vs. PPD: Know the Difference

Key distinction – impairment and duration

The Diagnostic Challenge

PPD is not the only diagnosis — and it may not be the right one.

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The Diagnostic Challenge

- Perinatal **anxiety** disorders are MORE common than PPD — and often overlooked
- Perinatal **OCD** is frequently misdiagnosed or missed entirely
- **Bipolar disorder** often first presents or is unmasked in the postpartum period
- **Postpartum psychosis** is less common but life-threatening — and can be mistaken for severe PPD

The Diagnostic Challenge

Misdiagnosis has serious consequences

The Diagnostic Challenge

- Treating bipolar disorder with an antidepressant alone can **trigger mania or rapid cycling**
- Missing OCD leads to **shame, secrecy, and delayed treatment**
- Missing psychosis can be **fatal**

Differential #1: Postpartum Anxiety (PPA)

Differential #1: Perinatal Anxiety Disorders

- Affect up to **20%** of pregnant and postpartum women
- **Frequently co-occurs** with PPD — but can present independently
- **Includes:**
  - Generalized Anxiety Disorder (GAD)
  - Panic Disorder
  - Specific phobias (including fear of childbirth)
  - Social anxiety disorder
  - PTSD/Perinatal trauma (addressed separately)

Perinatal Anxiety: Differentiating Features

- **Hallmarks of perinatal anxiety (vs. PPD):**
  - Excessive, uncontrollable **worry** — often focused on baby's health and safety
  - **Racing thoughts** — difficulty "turning off" the mind
  - **Physical symptoms** — racing heart, shortness of breath, dizziness, GI distress
  - **Hypervigilance** — checking on the baby repeatedly, unable to rest
  - **Avoidance** behaviors — refusing to be alone with the baby, avoiding certain activities
  - **Sleep disturbance** even when baby is sleeping (anxiety-driven, not mood-driven)

Perinatal Anxiety: Differentiating Features

Clinical Pearl

Ask: “Do you worry excessively about your baby’s health or safety, even when everything is fine?”

Differential #2: Postpartum OCD (POCD)

Differential #2: Perinatal OCD

- **Often unrecognized and undertreated — affects 3-5% of perinatal women.**

- Characterized by **intrusive, unwanted, ego-dystonic thoughts (obsessions) + compulsive behaviors or mental rituals**
- Perinatal OCD **most commonly** features **intrusive thoughts of harming the baby**
- **Mothers are typically horrified** by these thoughts — NOT at risk of acting on them
- **Avoidance** is common: refusing to be alone with baby, hiding sharp objects, not bathing the baby

Perinatal OCD: Differentiating Features

- **Common intrusive thought themes in perinatal OCD:**
    - Thoughts of dropping, shaking, or hurting the baby
    - Fears of accidentally suffocating or drowning the baby
    - Intrusive sexual thoughts involving the infant
    - Fears of contaminating or poisoning the baby

- **Associated compulsions and behaviors:**
    - Repeated checking (baby's breathing, locks, stove)
    - Reassurance-seeking from partner or providers
    - Avoidance of baby care tasks (diaper changes, baths, feeding)

Perinatal OCD: Differentiating Features

Clinical Pearl

Ask: "Do you have unwanted thoughts or images that pop into your mind and are hard to dismiss? Do you do anything to try to make those thoughts go away?"

Differential #3:
Bipolar Disorder (BD)

Differential #3: Bipolar Disorder

The postpartum period is the highest-risk time for bipolar disorder onset or relapse

Differential #3: Bipolar Disorder

- Up to **25%** of women presenting with "PPD" may have an underlying bipolar spectrum disorder
- Bipolar depression is **indistinguishable** from unipolar depression on presentation alone
- Starting an antidepressant without a mood stabilizer in undiagnosed bipolar disorder can **trigger** mania, mixed states, or rapid cycling

Differential #3: Bipolar Disorder

- **Risk factors for underlying bipolar disorder:**
  - Personal or family history of mania, hypomania, or mood episodes
  - Prior antidepressant-induced mood elevation
  - Postpartum psychosis in a previous pregnancy

Bipolar Disorder: Red Flags in the Perinatal Period

- **Watch for these features that suggest bipolar spectrum rather than unipolar PPD:**
  - Mood episodes that are unusually brief (days, not weeks)
  - Marked irritability or agitation rather than sadness
  - Decreased need for sleep without fatigue
  - Racing thoughts, pressured speech, inflated self-esteem
  - Impulsive behavior — spending, sexual, risky decisions
  - Prior antidepressant trial that caused mood elevation, agitation, or worsening
  - History of postpartum psychosis in a prior pregnancy

When in doubt — call us before treating!

Screening for Bipolar Disorder: The MDQ

- **Mood Disorder Questionnaire (MDQ) — use routinely, not just when you suspect it.**

- **How to administer:**
  - 13 yes/no symptom questions about periods of elevated or irritable mood
  - Ask about personal history AND family history of bipolar disorder, mania, or hypomania
  - Positive screen: 7+ "yes" answers, occurring in the same time period, with moderate-severe impairment

Screening for Bipolar Disorder: The MDQ

- **Clinical pearls:**
  - Family history matters even if the patient denies personal episodes
  - Patients may not recognize past hypomanic episodes as problematic
  - A positive MDQ warrants referral to psychiatry (or call to us!) before starting an antidepressant

Differential #3: Bipolar Disorder

Clinical Pearl

Ask directly: “Has anyone in your family been diagnosed with bipolar disorder, had rapid mood fluctuations, or been psychiatrically hospitalized?”

Differential #4:
Postpartum Psychosis (PPP)

Differential #4: Postpartum Psychosis

- **A psychiatric emergency — life-threatening.**
- As common as Down syndrome & cerebral palsy

- This is **NOT severe PPD** — PPP is a **distinct, acute psychiatric emergency** that is **temporary if treated**

Differential #4: Postpartum Psychosis

- Affects approximately **1-2/1,000** deliveries
- Can also occur after miscarriage or termination
- Onset typically within the first **2-21 days postpartum** — often days 3-14
- **Strongly associated with bipolar disorder — 50-80% of cases**
- **5%** risk of suicide, **4%** risk of infanticide
- **High risk of recurrence** in subsequent pregnancies — **up to 50-70%**

Differential #4: Postpartum Psychosis

- **Classic triad:**
  - Delirium (waxes & wanes)
  - Hallucinations
  - Delusions

Postpartum Psychosis: Emergency Signs

- **Early warning signs (hours to days):**
  - Insomnia without fatigue — staying up all night, not sleeping even when baby sleeps
  - Marked mood lability — rapidly shifting between elation, irritability, and tearfulness
  - Confusion, disorganized thinking, difficulty making sense
  - Hyperactivity, restlessness, pressured speech
  - Delusions & hallucinations

Postpartum Psychosis: Escalating Signs

- **Escalating signs — requires emergency evaluation NOW:**
  - Auditory or visual hallucinations
  - Delusions — often related to the baby (“the baby is possessed,” “my baby was switched”)
  - Paranoia, disorganized behavior, inability to care for self or baby
  - Thoughts of harming self or infant that are ego-syntonic (she may want to act on them)

Postpartum Psychosis: Escalating Signs

If you suspect postpartum psychosis — send to the ER immediately!

Do not leave the mother alone. This is a **psychiatric emergency.**

Clinical Pearls: Diagnostic Overlap

- **PMADs rarely present in isolation. Expect comorbidity.**

- **Depression + anxiety:** very common — up to 50% of women with PPD also have an anxiety disorder
- **OCD + depression:** intrusive thoughts worsen depressive guilt and shame
- **Bipolar + anxiety:** anxiety in bipolar disorder is often more prominent than mood elevation
- **PPP** often mistaken for PPD or anxiety due to mood & restlessness features — reassess frequently

Clinical Pearls: Diagnostic Overlap

- **When the patient isn't responding to treatment:**
  - Reconsider the diagnosis
  - Screen for bipolar disorder if not already done
  - Ask about OCD symptoms that may not have been disclosed
  - Reassess for psychotic features

When to Call ACCESS vs. When to Refer

- **Call ACCESS [1-833-978-MOMS (6667)] for consultation when:**
  - You're uncertain about diagnosis or want guidance on first-line treatment
  - Patient has mild-moderate PPD or anxiety and you'd like support managing
  - MDQ is borderline or positive and you want guidance before prescribing
  - Patient is reluctant to see psychiatry and you need next-step support
  - Symptoms are not responding to initial treatment

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Treatment Overview

- **First-line treatment depends on diagnosis, severity, and patient preference.**

- **Psychotherapy:**
    - CBT are first-line for mild-moderate PPD and anxiety
    - ERP (Exposure and Response Prevention) is first-line for OCD
    - Refer all patients for psychotherapy regardless of medication status

Treatment Overview

- **Medication:**
  - SSRIs are first-line for PPD and perinatal anxiety (sertraline most studied)
  - Do NOT start antidepressant alone in suspected bipolar disorder
  - Postpartum psychosis: requires antipsychotics, mood stabilizers, and often hospitalization

- **Always screen for bipolar disorder before prescribing an antidepressant.**

Thank You!

- **Questions?**
- Thank you for your commitment to perinatal mental health.