Postpartum Depression

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SUN. SCHOOL
9:00AM
WORSHIP
10:00AM

WE ARE
TOO BLESSED
TO BE DEPRESSED

Pastor
RAY ANDERSON
First documented mention of postpartum depression in the 11th century by female physician Trotula of Salerno

- If the womb is too moist, the brain is filled with water, and the moisture running over the eyes, compels them to shed involuntary tears.
Historical Context

Louis Victor Marcé, a French psychiatrist, wrote the first treatise entirely devoted to postpartum mental illness, published in 1858.
Charlotte Perkins Gilman

- Early feminist and writer
- The Yellow Wallpaper first published in 1892, a short story (fictionalized) recounting her postpartum depression after the birth of her daughter
- After 2 years, she sought help from a famous neurosurgeon who prescribed complete confinement
Modern Day Descriptions

Marie Osmond, from *Behind The Smile* (2001)

Brooke Shields, from *Down Came the Rain* (2005)
“Baby Blues”

- Occurs in 80% of mothers
- Starts in the first week and resolves in 7 - 14 days
- Emotional lability with tearfulness, irritability, worry
- Does not interfere with normal functioning
- Due to rapid hormonal changes, sleep deprivation
- No treatment necessary
Postpartum Depression: Prevalence

- The most common complication of childbirth
- Postpartum depression occurs in 10 - 13% of mothers
- ½ million woman in the US each year
- Over half of these women receive no treatment
- Occurs within the first 12 months postpartum (peaks between months 2 and 4)
Depression After Spontaneous Abortion

- Defined as pregnancy loss before 20 weeks gestation
- 20% women have depressive symptoms
- 30% women with recurrent spontaneous abortions have depressive symptoms
Edinburgh Postnatal Depression Scale

- Most extensively studied scale
- Focuses on emotional rather than physical symptoms
- 10-item scale
- Scored 0 – 3 for each item
- Most recommend cut-off score of 9/10
- Sensitivity ranges from 91% (specificity 76%) to 88% (specificity 72%)
- When is the ideal time to screen?
Description

- Sad mood, feelings of guilt, uncontrollable crying
- Loss of interest or pleasure
- **Excessive worry or anxiety** (ruminations common)
- Irritability or short temper
- Feeling overwhelmed, difficulty making decisions
- Hopelessness
- Sleep problems (often the woman cannot sleep or sleeps too much), fatigue
- Physical symptoms or complaints without apparent physical cause
- Discomfort around the baby or a lack of feeling toward the baby
- Loss of focus and concentration (may miss appointments, for example)
- Changes in appetite; significant weight loss or gain
- Suicidal thoughts or worrying about hurting the baby
Useful Questions Particular to PPD

- Are you anxious or worried?
- Can you sleep when the baby is sleeping?
- Do you ever think about harm coming to the baby or your child getting injured?
Risk Factors

- 50 to 80 percent risk if previous postpartum depression
- Depression or anxiety during pregnancy
- Personal or family history of depression/anxiety
- Social isolation or poor support
- Low SES
- Low literacy
- History of premenstrual syndrome (PMS) or premenstrual dysphoric disorder (PMDD)
- Bipolar disorder
EVALUATION AND DIFFERENTIAL DIAGNOSIS

- Rule out thyroid dysfunction
- Differentiate between “baby blues”, depression, psychosis
- Urgent psychiatric intervention and provision for patient’s safety if:
  - Patient has considered a plan to act on suicidal thoughts or has infanticidal thoughts
  - Major functional impairment
  - Signs/symptoms of mania or psychosis
- Reevaluate women in two weeks if:
  - Very mildly depressed without functional impairment
  - Score between 5-9 on Edinburgh Scale
- Everyone else: Treat
Etiology - Biology

- Rapid hormonal shifts
- No consistent evidence that estrogen or progesterone abnormalities are causative
- **Serotonergic system modulated by both estrogen and progesterone**
- Dopamine and norepinephrine also modulated by ovarian hormones
- Low cholesterol and omega-3 fatty acids have been correlated with postpartum depression
- Immunologic/genetic theories
Contributing Factors

- Traumatic obstetric experiences
- Sleep deprivation
- Role change or conflict
- Life stressors
- Ambivalence about the pregnancy
- Marital problems
- Infant temperament
Effects of Postpartum Depression

- Guilt
- Decreased self esteem
- Stigma
- Stressed relationships (separation, divorce)
- Paternal depression
- Negative effects on baby or older children
  - Poorer bonding, more likely to be insecurely attached
  - Less persistence in play with and less joy in reunion after separation from depressed mothers
  - ? Lower IQ
  - Increase in behavioral problems and psychiatric symptoms in older children
- Child abuse/neglect
- Substance abuse
- Suicide/infanticide
- Less likely to continue breastfeeding
Effects of Postpartum Depression
Infant Development

- **Cognitive development**
  - Poorer infant mental and motor development (controlled for maternal IQ)
  - Poorer object permanence

- **Emotional Development**
  - Less interactive
  - Poorer concentration
  - Less sociable with strangers
  - More negative responses (protest behavior, temper tantrums)
  - Insecure attachment, primarily avoidance (as opposed to anxious)
  - Mothers more likely to report behavioral difficulties
Mediating mechanisms

- Exposure to depressive symptoms
- Environmental adversity resulting from depression
- Genetic factors
- Parenting difficulties associated with the occurrence of maternal depression
Effects of Postpartum Depression
Infant Development

The primary determinant of infant behavior of depressed mothers may be a particular form of maternal responsiveness

– Withdrawn
– Intrusive
Effects of PPD on Toddlers

- 3 ½ year old children of mothers with PPD both chronic and remitted, have altered left frontal brain activity and an increase in behavioral problems.
REMEMBER

- Depression itself is a risk factor for poor outcomes
- This needs to be considered when weighing the risks/benefits of treatment (esp while nursing)
- Women sometimes think that “natural is best” and it is important to review with them the effects of untreated depression
Treatment

- Biological Interventions
- Non-biological Interventions
Biological Interventions

- Antidepressants
- Hormones
- Phototherapy
- Omega-3 Fatty Acids
- Electroconvulsive Therapy
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<thead>
<tr>
<th>Class</th>
<th>Drug</th>
<th>Trade Name</th>
<th>FDA Class</th>
<th>Starting Dose</th>
<th>Dose Range (mg/day)</th>
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<td>MAOI</td>
<td>Phenelzine</td>
<td>Nardil</td>
<td>C</td>
<td>15 qam</td>
<td>60-90 per day, tid dosing</td>
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<td>Parnate</td>
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<td>Elavil</td>
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<td>Aventyl, Pamelar</td>
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<td>50-200qd</td>
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<td>SNRI</td>
<td>Duloxetine</td>
<td>Cymbalta</td>
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<td>Wellbutrin</td>
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Decision to Nurse While Taking Medication

- Risk/benefit analysis
- Other factors re pro’s/con’s nursing
  - For mother
  - For infant
Use of Sertraline While Nursing

- Best data
- Blood levels in infants undetectable or extremely low
- No behavioral, developmental differences
- “pump and dump” 8 hours after medication may decreases exposure by 20%

*Newport, DJ, J Clin Psychiatry 63 Suppl 7: 31-44 (2002)*
Antidepressants and Breastfeeding

- Nortriptyline, paroxetine, or sertraline seem unlikely to develop detectable or elevated plasma levels.
- Infants exposed to fluoxetine appear to be at higher risk of developing elevated levels, especially following prenatal exposure or if levels are high in the breast milk.
- Citalopram may produce elevated levels in some infants, especially if the maternal dose or breast milk level is high.
Psychotherapy and Psychosocial Interventions

- **Psychotherapy**
  - IPT and CBT
  - 10 studies, 5 RCT

- **Psychosocial Interventions**
  - Peer Support (esp. telephone based)
  - Partner Support
  - Nondirective counseling
Other Interventions

- Relaxation/massage therapy
- Infant sleep interventions
- Maternal exercise
Psychodynamic Conflicts

- **Dependence**
  - Often with a counterdependent adaptation
  - A new mother needs to be taken care of
  - One has to cope with an infant’s constant demands
  - Women who need to prove they can handle everything may be particularly vulnerable

- **Own Mothering**
  - Conflicted identifications of the patient with her mother
  - May feel mother didn’t enjoy being a mother
  - May have had little positive role-modeling
  - May fight against being like own mother only to find…

- **Anger**
  - Guilty inhibition of anger towards others
  - Being a mother is frustrating
  - Women who cannot identify and tolerate anger may become depressed
What Should be Accomplished in The First Appointment

- Determine diagnosis
  - Rule out bipolar disorder, thyroid dysfunction
- Determine whether patient can be treated as an outpatient or whether inpatient hospitalization is indicated
- If hospitalization is needed, refer to closest ER
- If outpatient, refer ASAP to M.D and therapist
What Should be Accomplished in The First Appointment

- Reassurance is critical
  - Explain the difference between ruminations and delusions
  - Normalize and validate, this is a silent disease that is not culturally sanctioned
  - Reassure that it is a very treatable illness (this is where you can explain that healthy mom = healthy baby)

- Increase care for mother
  - Encourage and normalize getting help with household chores or older children
  - Encourage her to spend a little time alone
What Should be Accomplished in The First Appointment

- Do not allow family to take over care of infant unless there is a safety issue as this can be counterproductive exacerbating feelings of failure and deprivation.
- Encourage flexibility (does she have to do all the feedings, what will she think of herself if she has a bad day), this addresses feelings of guilt.
- Allow ventilation of anger.
- Explain issues of bonding (it takes longer than you think).
- Remind her of the resilience of children.
Prevention

- Antepartum screening
  - Risk factors for postpartum depression
  - Signs/symptoms of psychiatric illness during pregnancy
  - Planning for support postpartum
  - Consideration of prophylactic medication

- Postpartum screening for early detection
  - 1 and 2 week telephone check-in, especially for identified high risk patients
  - Frequent follow-up, especially first 3 months
Prevention

- Brief IPT was found to decrease PPD by 50% at 3 months postpartum (Zlotnick 2006)
- But overall, psychosocial interventions have not been found to be preventive although intensive, individual postpartum support by health care professionals has the best data (Dennis, CL 2006)
- Sertraline found to be preventive in 2 trials (Wisner 2006)
3rd Trimester Visit

- If you are lucky enough to already be working with the family
- Bring in partner
- This really helps outline everyone’s roles and allows for expectations to be discussed
- Partner/family take care of mother, mother takes care of infant
Postpartum Support International
www.postpartum.net
Conclusion

- Postpartum depression is a common illness affecting approximately 10 - 13% of women.
- There is a biologic underpinning which can be exacerbated by psychological and social issues.
- Untreated postpartum depression can have a negative impact on a woman’s quality of life, relationships, and children.
- Women should be encouraged to seek treatment without fear of being stigmatized.
- Treatments include biologic and non-biologic interventions.