Postpartum Mood Disorders

1.0 Contact Hour

Presented by:

CEU Professor®

www.CEUProfessorOnline.com

Postpartum Mood Disorders

By Joe Knight, PA-C

Objectives:

1. List the three most common postpartum mood disorders and the major criteria of each.
2. List the major risk factors of postpartum mood disorders.
3. List the two greatest concerns with a patient suffering from postpartum psychosis.
4. List the two blood tests that are mandatory in your evaluation of a patient suffering from a postpartum mood disorder, and explain the rationale for these tests.
5. List the non-pharmacological therapies that have at least some scientific basis, and the mechanism-of-action for each.

Introduction

The general public tends to think of pregnancy as a time of well-being for most women and their families; however, a substantial number of women will state that the time of pregnancy and motherhood are the most disturbing period of their lives.[1] Over the last 40 years, most research has focused on the three most common post-natal psychiatric disorders – postpartum blues, postpartum depression and postpartum psychosis. It has long been known that the postpartum period represents a time of heightened susceptibility to the new onset of depression and an increased risk of being hospitalized.[2] Many have assumed that the pregnancy itself offers protection against mental illness; however, longitudinal studies have shown that pregnancy offers no protection against the occurrence or reoccurrence of major depression.[3]

Pathogenesis

The specific etiology of postpartum mood disorders (PPMDs) has not been determined. A convergence of genetic susceptibility,[4] hormonal changes,[5] and life stressors [6] may lead to depression; however, no single factor has been identified as the causative agent.[7] Biological factors such as sleep deprivation have also been considered to contribute to the development of PPMDs.[8] It has been noted that progesterone has significant sedative properties, [9] and since progesterone levels drop significantly after childbirth, this drop may lead to insomnia.[8]

Risk factors

If any of a patient's first-degree relatives have had a history of depression, the patient has a 1.5-to-3 times greater chance of developing depression relative to the general population;[10] therefore, any family history of depression increases the risk for any given patient.[11] Other psychosocial factors that increase the risk for depression include unplanned pregnancy, ambivalence about the pregnancy, poor social support, marital difficulties and adverse life events.[12]

Postpartum blues and depression

Risk factors for the "postpartum blues" include a history of depression, depressive symptoms during pregnancy, a family history of depression, premenstrual mood changes, and psychosocial impairment at work or during relationships.[13, 14] Women suffering from postpartum blues experience sadness, crying spells, irritability, anxiety, and sleep disturbances. The blues usually begin during the first week after the baby arrives, and can last anywhere from a few hours to a few weeks. Postpartum blues is so common that health care providers consider it a normal variant of normal maternal behavior rather than a true psychiatric problem.

Postpartum depression

One of the main risk factors for postpartum depression is prenatal depression.[15, 16] Other factors that may be involved in postpartum depression are chronic stressors (such as financial difficulties), stressful life events, unplanned pregnancy and ambivalence about the pregnancy, [17] while a history of sexual abuse is the greatest risk factor for prolonged postpartum depression.[18]

While postpartum blues usually occurs hours to days after delivery, postpartum depression can occur anytime within the first six months of delivery. Postpartum depression sometimes correlates with the resumption of menstruation or after the mother stops breastfeeding. Postpartum depression is more disabling and persistent than postpartum blues. Women with postpartum depression may experience despair, hopelessness and loss of normal interests. One of the most profound problems is a feeling of guilt. The mother may feel guilty about her perceived lack of maternal feelings, which causes further despair, which causes further guilt. This can lead to a real depressive spiral. Unlike postpartum blues, postpartum depression can be serious. Postpartum depression can result in the inability of the mother to function effectively, which can significantly disrupt the harmony of family life. The mother may remain depressed for months if she doesn't get help.

Postpartum Psychosis

Postpartum psychosis is an extremely serious problem that can affect the mother's perception of reality. Postpartum psychosis affects one or two women out of 1000. She can experience hallucinations, delusions, severe depression, and confusion. Postpartum psychosis usually occurs within thirty to sixty days of childbirth.[19] Among patients who develop postpartum psychosis after childbirth, 72%-to-88% have bipolar illness or schizoaffective disorder, whereas only 12% have schizophrenia.[20] Postpartum psychosis has a dramatic onset, emerging as early as the first 48-72 hours after delivery; however, in most women, symptoms develop within the first two postpartum weeks.[19] The risk of a mother harming her baby is quite high if she has postpartum psychosis. Mothers with this problem usually have delusions of the infant being possessed with extraordinary

powers, usually of an evil nature. Auditory hallucinations, such as 'Kill the baby before it kills you,' are not uncommon.

The risk of a patient experiencing an episode of postpartum partum psychosis is one out of 500; however if she has had at least one previous episode, the risk rises to one out of seven.[21] Women with a history of bipolar disorder or schizoaffective disorder have a greater than 50% risk for another episode of postpartum psychosis.[22] In the first year after childbirth, suicide risk increases 70-fold. Suicide is the leading cause of maternal death up to one year after delivery; of 1000 women with postpartum psychosis, two complete suicide.[23] Any postpartum patient who hints at or discusses suicide should be taken seriously and emergency psychiatric evaluation should be arranged.

Treatment of PPMDs

So what can be done for women who have a problem with a postpartum mood disorder? First of all, nothing can be done if the woman doesn't acknowledge a problem exists. Any woman who has just had a baby needs to recognize that she may have a mild case of "baby blues" after delivery. All the guests have gone home, the husband has returned to his normal work schedule, and the other kids at home have (finally) calmed down. The mother is expected to be doing well by this time, and it is also assumed that she is coping well on her own. But what if she's not?

Unless a severe problem develops, time is a big help. Most women with postpartum blues start to feel better after two or three weeks. The biggest thing that would help is the love and support of the woman's husband or significant other. If he understands what is going on, he'll be in a better position to be supportive. But what if the irritability, the sleeplessness, and the mood swings become more pronounced? Then the possibility exists that postpartum depression may be setting in.

A thorough medical history and physical examination should be performed and laboratory tests ordered. The laboratory tests that should be considered are thyroid function tests (TFTs), because hypothyroidism may mimic depressive symptoms, and a

complete blood count (CBC) to determine if anemia could be causing fatigue and irritability.

Nonpharmacological treatments should be considered for women with mild-to-moderate depressive symptoms. Individual or group psychotherapy, or support groups could be beneficial. These modalities are especially attractive to mothers who are nursing and who wish to avoid taking medications.[19] Research has clearly demonstrated that a lack of social support is a significant predictor of postpartum depression; therefore, peer support interventions potentially have beneficial effects in women who have mild-to-moderate depression or for women who have no history of depression. The role of the husband or significant other plays an important part in the prevention of or recovery from postpartum depression. Partners can share in childcare and domestic chores, and can mediate between the woman suffering from depression and family members who may not understand the problem.[24]

Bright light therapy, also used for the treatment of Seasonal Affective Disorder,[25] produces an antidepressant effect in a study of 16 pregnant patients with major depression [26] and in two women with postpartum major depression.[27] Since it is well-tolerated and does not expose the nursing-infant to medications, it may be a promising treatment for postpartum depression.[28]

Alternative therapies that may be considered are massage therapy, relaxation therapy, acupuncture, homeopathy, herbs and dietary supplements; however, data determining the effectiveness of these treatments are lacking.

Pharmacological treatment is indicated for moderate-to-severe depressive symptoms or when a woman does not respond to nonpharmacological treatment. Medication should be considered in addition to the nonpharmacological therapies.[19] First-line agents to be considered are the selective serotonin reuptake inhibitors (SSRIs) such as Prozac, Zoloft, Paxil and Celexa. Adverse side effects of this class of medications are insomnia, jitteriness and headache.[19] If SSRIs are ineffective, the serotonin-norepinephrine

reuptake inhibitors (SNRIs), such as Effexor and Cymbalta may be tried. Adverse side effects of this class of medications include nausea, dry mouth, fatigue and dizziness.[29] Typically, symptoms start to diminish in 2-4 weeks. A full remission may take several months. In partial responders, increasing the dosage may be helpful.[19]

Patients with a diagnosis of postpartum psychosis need special care. The treatment of these patients is beyond the scope of this paper, other than to say the patient needs the immediate intervention of a psychiatrist for immediate and long-term treatment.

Conclusion

Since early postpartum hospital discharge is becoming more common, postpartum mood disorders may go unrecognized by the hospital staff as the mother and her child are discharged. It is important for all clinicians who provide well child examinations and postnatal follow-ups to be attuned to any special concerns that your patient may explicitly or implicitly exhibit.

References

1. Lusskin SI, Pundiak TM, Habib SM. Perinatal depression: Hiding in plains sight. *Can J Psychiatry*. 2007;52:479-488.

2. Munk-Olsen T, Laursen T, Pedersen C, et al. New parents and mental disorders: a population based register study. *JAMA*. 2006;296(21):2582-2589.

3. Cohen LS, Altshuler LL, Harlow BL, et al. Relapse of major depression during pregnancy in women who maintain or discontinue antidepressant treatment. *JAMA*. 2006;295(5):499-507.

4. Josefsson A, Sydsjo G, Berg G, et al. CYP2D6 genotypes and depressive symptoms during late pregnancy and postpartum *Nord J Psychiatry*. 2004;58(1):61-64.

5. Bloch M, Schmidt PJ, Danaxeau M, et al. Effects of gonadal steroids in women with a history of postpartum depression. *Am J Psychiatry*. 2000;157(6):924-930.

6. Wilson LM, Reid AJ, Midner DK, et al. Antenatal pschosocial risk factors associated with adverse postpartum family outcomes. *CMAJ*. 1996;154(6):785-799.

7. McCoy SJ, Beal JM, Watson GH. Endocrine factors and postpartum depression. A selected review. *J Reprod Med*. 203;48(6):402-408.

8. Ross LE, Murray BJ, Steiner M. Sleep and perinatal mood disorders: a critical review. *J Psychiatry Neurosci*. 2005;30(4):247-256.

9. Smith MJ, Keel JC, Greenberg BD, et al. Menstrual cycle effects on cortical excitability. *Neurology*. 1999;53:2067-2072.

10. McGuffin P, Marusic A, Farmer A, et al. What can psychiatric genetics offer suicidology? *Crisis*. 2001;22(2):61-65.

11. Forty L, Jones L, Macgregor S, et al. Familiality of postpartum depression in unipolar disorder: results of a family study. *Am J Psychiatry*. 2006;163(9):1549-1553.

12. Beck C. A meta-analysis of predictors of postpartum depression. *Nurs Res*. 1996;45:297.

13. O'Hara MW, Schlechte JA, Lewis DA, et al. Prospective study of postpartum blues. Biologic and psychosocial factors. *Arch Gen Psychiatry*. 1991;48(9):801-806.

14. Bloch M, Rotenberg N, Koran D, et al. Risk factors for early postpartum depressive symptoms. *Gen Hosp Psychiatry*. 2006;28(1):3-8.

15. Dennis CL, Ross LE. The clinical utility of maternal self-reported personal and familial psychiatric history in identifying woman at risk for postpartum depression. *Acta Obstet Gynecol Scand*. 2006;85(10)1179-1185.

16. Kitamura T, Yoshida K, Okano T, et al. Multicentre prospective study of perinatal depression in Japan: incidence and correlates of antenatal and postnatal depression. *Arch Womans Ment Health*. 2006;9(3):121-130.

17. Robertson E, Grace S, Wallinton T, et al. Antenatal risk factors for postpartum depression: a synthesis of recent literature. *Gen Hosp Psychiatry*. 2004;26(4):289-295.

18. Buist A, Janson H. Childhood sexual abuse, parenting and postpartum depression – a 3-year followup study. *Child Abuse Negl*. 2001;25(7):909-921.

19. Nonacs RM (2007) Postpartum depression. Available online at http://www.emedicine.com/med/topic3408.htm Accessed February 24, 2008.

20. Wisner K, Peindl K, Hanusa B. Psychiatric episodes in woman with young children. *J Affective Disord*. 1995;34:1.

21. Kendell R, Chalmers J, Platz C. Epidemiology of puerperal psychoses. *Br J Psychiatry*. 1987;150:662.

22. Jones I, Craddock N. Familiality of the puerperal trigger in bipolar disorders: Results of a family study. *Am J Psychiatry*. 2001;158:913.

23. CMED. Confidential inquiries into maternal deaths: Why mothers die. 1997-99. London: Royal College of Obstetricians and Gynaecologists, 2001.

24. Dennis CL. Treatment of postpartum depression, part 2;a critical review of nonbiological interventions. *J Clin Psychiatry*. 2004;65(9):1252-1265.

25. Knight J, Russo G. Seasonal Affective Disorder. *Advance Phys Asst*. 2000;10:51-52.

26. Oren DA, Wisner, Spineli M, et.al. An open trial of morning light therapy for treatment of antepartum depression. *Am J Psychiatry*. 2002;159(4):666-669.

27. Corral M, Kuan A, Kostaras D. Bright light therapy's effect on postpartum depression. *Am J Psychiatry*. 2000;157(2):303-304.

28. Hendrick V. Alternative Treatments for Postpartum Depression. *Psychiatric Times*. 2003;10(8). Available online at http://www.psychiatrictimes.com/p030850.html. Accessed February 25, 2008.

29. The Physician Assistants' Prescribing Reference. 2007-2008;14(4). Prescribing References, Inc. New York.