eMentalHealth.ca

Postpartum Depression: Information for Primary Care

Image credit: Adobe Stock

Summary: Postpartum depression refers to a major depressive episode which occurs in the time period up to a year after childbirth (i.e. post-partum). Although often under recognized, it is a serious condition that can cause serious harm to both the mother, child and affect the whole family. All new mothers should be screened for depression. Screening tools include the Edinburg Postnatal Depression Scale (EPDS). For mild to moderate postpartum depression, it is reasonable to start with ensuring adequate social support, psychotherapy, and other non-medication options. For moderate to severe postpartum depression, patients will most likely benefit from a combination of social support, medications and psychotherapy.

Case

- J. is a 30-yo woman who is a new mother with a 6-month old.
- Her husband often comes home late from work and unfortunately, there is not much extended family support
- J. presents to clinic: “I’ve always wanted to have a baby of my own, but it's a lot more work than I thought. I’m just exhausted and crying all the time!”

Epidemiology

- Prevalence
    - During pregnancy
        - Prenatal, antepartum depression ~ 10% (Chatillon, 2010)
    - After birth
        - Baby blues ~ 60-80% (Gavin, 2005)
        - Postpartum depression ~ 13% (Gavin, 2005).
        - Postpartum psychosis ~ 0.1-0.4% (Terp, 1998)
- Depression is the most common complication of childbirth (Wisner, 2013)
- Suicide is the leading cause of maternal death in the developed world (CEMACH, 2007)

Diagnosis

- Postpartum depression is a major depressive episode that occurs within a year after the birth, with:

- Depressed mood or irritable mood, including crying spells, sadness
- Neurovegetative symptoms such as poor sleep, energy, concentration, appetite
- Symptoms that are above and beyond what would be expected post-delivery

DSM-5

- DSM-5 recognizes postpartum depression with the existence of a specifier of “With Peripartum Onset” which can be applied to diagnoses such as major depressive disorder, bipolar I disorder, bipolar II disorder, or brief psychotic disorder.
- Unlike most definitions of postpartum depression which accept up to a year after delivery, the DSM-5 specifies that the onset of postpartum symptoms must be within 4-weeks of postpartum.

Clinical Presentation

- Many women may be reluctant to disclose their symptoms of depression out of fear, shame and embarrassment.

Complications

- Diagnosis of postpartum depression is often missed as the problems with mood are attributed to being a new mother, however the consequences of untreated postpartum depression are significant
- There are all the same complications of depression, but because a mother is involved, it carries all the consequences of harm to not just the mother, but also the child, as well as relationships with the partner and any other children
- Short-term complications
  - At its extreme, adverse effects include:
    - Suicide: Suicide is the leading cause of postnatal maternal death in developed countries
    - Neonaticide / Infanticide: Death of the child.
  - Impaired physical/emotional development
  - When a mother is so overwhelmed that she is unable to provide for a child’s needs, it impairs normal physical and emotional development
- Long-term complications
  - When a child’s needs are not met, the child learns at a deep level that the world is unsafe, which predisposes the child to later developing mental health issues such as depression and anxiety

Screening for Postpartum Depression

Clinicians should screen patients at least once during the perinatal period for depression and anxiety symptoms (i.e. the period during pregnancy and up to a year after the delivery) (The American College of Obstetricians and Gynecologists, 2015).

This can be done through clinical interview and/or validated scales:

1. Screening questions on clinical interview

- "During the past month, have you often been bothered by feeling down, depressed, or hopeless?”
- “During the past month, have you often been bothered by having little interest or pleasure in doing things?”
- If the woman answers “Yes” to either question, then follow-up with: “Is this something you feel you need or want help with?”

2. Edinburgh Postnatal Depression Scale (EPDS)

- The EPDS (10-item self report) is the most widely used, validated screening instrument for both antepartum and postpartum depression

- It is free to use as long as the author names, title and source are reproduced in all copies
- Sensitivity: 86-100%/Specificity: 78-90%
- Scoring
    - Ranges from 0-30
    - Cut-off scores:
        - 10-12 indicates risk for depression
        - >12 indicates positive screen for depression
        - 14/15 for probable depression in pregnant women

History

HPI

- For new mothers
    - How have things been since your child was born?
    - How do you feel about being a mother?
    - Any feelings of guilt?
    - Do you feel close to your child?
    - Do you have any fantasies of running away from it all?”
- Current and past stressors
    - Problems sleeping?
    - Traumatic delivery?
    - Problems with infant health?
    - Fetal demise?
    - Conflict with father/partner?
    - Lack of supports
- Inventory of available social supports, particularly those in a position to offer practical assistance with the care of a newborn
    - Who can you turn to for help?
    - Is there anyone that can help out with the baby, such as childcare for a few hours so you can sleep?
- Depression review of symptoms
    - Onset, frequency, duration and severity of depressive symptoms
- Suicide / homicide risk
    - Has it ever gotten to the point where you’ve felt that life isn’t worth living?
    - Any thoughts of harming yourself?
    - Any thoughts of harming your child?
    - Any thoughts of harming others?
    - How strong are those thoughts? What stops you from acting on those thoughts?
    - On a scale between 0 and 10, where 0 is “none at all”, and 10 is “the most”, how likely are you to act these thoughts of harming yourself (or your child)?
- For new mothers
    - How have things been since your child was born?
    - How do you feel about being a mother?
    - Any feelings of guilt?
    - Do you feel close to your child?
    - Do you have any fantasies of running away from it all?”
- Current and past stressors
    - Problems sleeping?
    - Traumatic delivery?
    - Problems with infant health?
    - Fetal demise?

    - Conflict with father/partner?
    - Lack of supports
- Inventory of available social supports, particularly those in a position to offer practical assistance with the care of a newborn
    - Who can you turn to for help?
    - Is there anyone that can help out with the baby, such as childcare for a few hours so you can sleep?
- Depression review of symptoms
    - Onset, frequency, duration and severity of depressive symptoms
    - Suicide / homicide risk
    - Has it ever gotten to the point where you've felt that life isn't worth living?
    - Any thoughts of harming yourself?
    - Any thoughts of harming your child?
    - Any thoughts of harming others?
    - How strong are those thoughts? What stops you from acting on those thoughts?
    - On a scale between 0 and 10, where 0 is "none at all", and 10 is "the most", how likely are you to act these thoughts of harming yourself (or your child)?

Psychiatric history

- History of past depressive episodes, including postpartum episodes?
- History of premenstrual dysphoric symptoms

Family history

- Any family history of depression? Any depression during the pregnancy? Any depression after the delivery?

Medications

- Any medications?
- Any herbal / vitamin remedies, such as to increase lactation?

Substance use

- Any use of alcohol?
- Any cigarettes? Any recreational drugs such as pot?

DDx of Postpartum Depression

	Screening question	Features	Management Essentials
Post-partum blues	Is it sadness occurring soon after delivery, but insufficient to meet criteria for major depression (or psychosis)	60-80% of women Onset a few days after delivery Resolves within 2-weeks without significant intervention Sadness, mood swings, crying, problems with concentration, anxiety, irritability Retain insight into the excessive nature of the symptoms	Resolves spontaneously Find ways to support mother's sleep, such as increased help from the father Monitor

Post-partum psychosis	Are there symptoms of psychosis, occurring within 1-year of the child's birth? Are you hearing or seeing any things? Any worries about the baby?	Delusions, hallucinations, sleep problems Obsessive (intrusive, egodystonic) thoughts about harming the baby can occur in 50% of all women True homicidal ideation is egosyntonic, usually as part of psychotic delusion or depressive thoughts Rapid mood swings (may resemble bipolar) Extreme anxiety, agitation Onset usually rapidly within first month of delivery	Postpartum psychosis is a psychiatric emergency that requires immediate intervention Refer to hospital for possible admission Contact child welfare to ensure the child is cared for
Post-partum depression	Are there 1) symptoms of major depression that is 2) occurring within 1-year of a child's birth?	10% have some postpartum depression which can last a year Onset: Anytime within a year of the delivery	Requires intervention

Medical DDx

- Thyroid disease
- Diabetes
- Anemia
- Vitamin deficiencies

Investigations

- Standard bloodwork such as
- TSH for thyroid screening
- CBC for anemia
- Urine dip / serum glucose for diabetes
- B12/ folate for vitamin deficiencies

Physical Exam

- Comprehensive physical exam to rule out medical contributors

Management of Post-Partum Depression: Education

The following key points are helpful to discuss with new mothers and their support network:

- Ensure that the new mother receives at least 5-hrs uninterrupted sleep every day
    - Chronic sleep deprivation from having a newborn contributes to postpartum depression
    - The new mother needs to be supported so that she can have at least 5-hrs of uninterrupted sleep in order to recover
    - Partners and other family supports need to find a way to support the mother so that this can happen
    - For more information, see the McMaster Sleep Protocol, Steiner 2002
- Ensure there are circles of support
    - Educate partner and family members on the importance of providing support to the new mother
    - Try to ensure that the patient has a support network, which may include
        - Health care provider

        - Peer telephone support
        - Programs such as Healthy Babies, Healthy Children
        - Partners (note that the incident of depression in father is ~ 10%)
        - Family, friends, neighbours
- Proper nutrition:
    - Ensuring that the new mother continues to support that she has opportunities to have proper meals and snacks.
- Exercise:
    - Ensuring that the new mother has opportunities to exercise such as walks with the baby (ideally outside, in order to have the benefit of nature and sunlight).
- Household and other practical support
    - Traditionally, new mothers had household help and other assistance in caring for a new infant, however this is often lacking in a modern society where there is often less support from extended family and community supports than in the past
    - Options to consider include
        - Any family or friends that can provide support?
        - Hired help such as a nanny or housekeeper?
- Is the new mother working?
    - Consider leave of absence from work or decreased work hours to reduce stress and allow time for recovery
- Accept and validate whatever choice mother has made with breastfeeding; do not pressure the mother to breastfeed
    - Regardless of what choice mother has made on whether to breastfeed or not, validate mother's choice
    - If mother is breastfeeding, validate the mother's choice without pressure
    - If mother is having challenges with her breastfeeding, then let the mother know that there are other options (e.g. pumping and offering bottles; supplementing or switching altogether to formula), and not to feel pressured that she has to breastfeed
    - If mother is not breastfeeding, then validate the mother's choice; what is best for the baby, is a mother who is emotionally well; what helps a mother be emotionally well, is if she feels accepted and supported, as opposed to criticized and judged
    - No co-sleeping if mother is taking sedating medications: Ensure that if the mother is using medications that cause sedation (e.g. sleeping medications, alcohol or marijuana), that she is not co-sleeping with the baby.
- Engage other multidisciplinary team members such as nursing.
    - Public Health Nurses have frequent contact with women during the perinatal period and are well positioned to detect women experiencing depression who are often reluctant to seek help.

Management: Treatment

- Refer to a mental health service or professional that can provide mental health support

Management: Medications

- Consider risks of medication (to mother, fetus or newborn) vs. risks of untreated disease (to mother, fetus, child, family, which includes risk of suicide and homicide)
- For a lactating mothers
    - If the mother is breastfeeding, what is safe for breastfeeding is <10% excretion of all medications (for all medications, not just psychotropic medications)
    - Most medications fall under the safe zone, except lithium and benzodiazepines

Specific serotonin reuptake inhibitor (SSRIs)

Medication	Starting dosage	Usual therapeutic target	Maximum dosage	Adverse effects
Citalopram (Celexa)	10 mg	20-40 mg	60 mg	Headache, nausea, diarrhea, sedation, insomnia, nervousness
Escitalopram (Cipralex)	5 mg	10-20 mg	20 mg	Same
Fluoxetine (Prozac)	10 mg	20-40 mg	80 mg	Same Note that neonates (i.e. newborns less than 4-weeks) may be vulnerable to accumulation due to Fluoxetine's long half-life
Paroxetine (Paxil)	10 mg	20-40 mg	50 mg	Same
Sertraline	25 mg	50-100 mg	200 mg	Same

Serotonin-norepinephrine reuptake inhibitors (SNRIs)

Medication	Starting dosage	Usual therapeutic target	Maximum dosage	Adverse effects
Desvenlafaxine, extended release (Pristiq)	50 mg	50 mg	100 mg	Headache, nausea, diarrhea, sedation, insomnia, tremor, nervousness, loss of libido, delayed orgasm, sustained hypertension
Duloxetine (Cymbalta)	20 mg	30 to 60 mg	60 mg	Same as SSRIs
Venlafaxine, extended release (Effexor XR)	37.5 mg	75 to 300 mg	300 mg	Same as desvenlafaxine

Safety of SSRIs in pregnancy

- In Canada, consider contacting MotherRiskfor the most up-to-date information regarding medicationsin a pregnant or nursing mother (www.motherisk.org)

Case

- J. is a 30-yo woman who is a new mother with a 6-month old. Her husband often comes home late from work and unfortunately, there is not much extended family support
- J. presents to clinic: "I've always wanted to have a baby of my own, but it's a lot more work than I thought. I'm just exhausted and crying all the time!"
- You diagnose J. with postpartum depression
- You meet with her and her husband, and provide education about postpartum depression
- You strongly emphasize the importance of 5-hrs of uninterrupted sleep and her husband finds a way to make this possible
- You see her in follow-up and she is still tired and exhausted, but her mood is significantly better and she is feeling hopeful

References

- Committee Opinion: Screening for Perinatal Depression, American Congress of Obstetricians and Gynecologists, May 2015. Retrieved Aug 8, 2015

from http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Screening-for-Perinatal-Depression

- Gavin NI, Gaynes BN, Lohr KN, Meltzer-Brody S, Gartlehner G, Swinson T. Perinatal depression: a systematic review of prevalence and incidence. Obstet Gynecol 2005;106:1071–83.
- Steiner M, Fairman M, Jansen K, Causey S. Can postpartum depression be prevented? [abstract]. Marcé Society International Biennial Scientific Meeting; 2002 Sep 25–27; Sydney, Australia.
- Terp IM, Mortensen PB: Post-partum psychoses. Clinical diagnoses and relative risk of admission after parturition. Br J Psychiatry. 1998;172:521.

Practice Guidelines

- Best Practice Guidelines for Mnetal Health Disorders in the Perinatal Period, by the BC Reproductive Mental Health Program and Perinatal Services BC, Mar 2014. Retrieved July 11, 2015 from http://reproductivementalhealth.ca/resources/best-practice-guidelines-mental-health-perinatal-period.

About this Document

Written by Drs. Jasmine Gandhi (Psychiatrist and Head, Perinatal Mental Health Program, Ottawa Hospital) and members of the eMentalHealth.ca Primary Care Team, which includes Drs. Mireille St-Jean (Family Physician, Ottawa Hospital), Eric Wooltorton (Family Physician, Ottawa Hospital), Farhad Motamedi (Family Physician, Ottawa Hospital) and Dr. Michael Cheng (Psychiatrist, Children’s Hospital of Eastern Ontario).

Disclaimer

Creative Commons License