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The Challenges of Postpartum Depression

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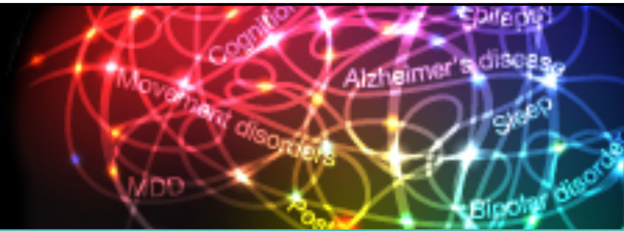
Disclosures



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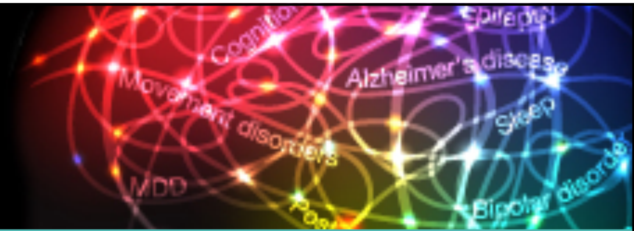
Learning Objective 1

Apply multidisciplinary management approaches to facilitate treatment and improve long-term clinical outcomes for patients with postpartum depression

Clinical Features of Postpartum Disorders



Postpartum Blues

- aka ”baby blues”
- Emotional lability following childbirth, characterized by frequent crying episodes, irritability, confusion, and anxiety; sometimes elation during first few days following birth
- Symptoms present up to 14 days and peak around 3 – 5 days; generally do not interfere with social or occupational functioning
- Symptoms not severe and do not need treatment

Postpartum Depression

- Difficult to distinguish from depression occurring at any other time in a woman’s life
- Negative thoughts mainly related to the newborn; feelings of guilt or inadequacy about ability to care for infant; pre-occupation with infant’s well-being or safety
- Can occur any time during the first year after childbirth
- Last longer and more severe than postpartum blues
- Requires treatment

Postpartum Psychosis

- Acute, abrupt onset; usually observed within first 2 weeks following delivery, or at most, within 3 months postpartum
- Symptoms include elation, lability of mood, rambling speech, disorganized behavior, and hallucinations or delusions; but may be transient episodes of delusions of guilt, persecution, auditory hallucinations; delirium-like symptoms and confusion; excessive activity
- Should be regarded as a psychiatric and obstetrical emergency

Rai S, et al. *Indian J Psychiatry*. 2015;57(suppl 2):S216-S221.

Screening Tool: Edinburgh Postnatal Depression Scale (EPDS)

1. I have been able to laugh and see the funny side of things
- ❑ As much as I always could
- ❑ Not quite so much now
- ❑ Definitely not so much now
- ❑ Not at all

2. I have looked forward with enjoyment to things
- ❑ As much as I ever did
- ❑ Rather less than I used to
- ❑ Definitely less than I used to
- ❑ Hardly at all

***3. I have blamed myself unnecessarily when things went wrong**
- ❑ Yes, most of the time
- ❑ Yes, some of the time
- ❑ Not very often
- ❑ No, never

4. I have been anxious of worried for no good reason
- ❑ No, not at all
- ❑ Hardly ever
- ❑ Yes, sometimes
- ❑ Yes, very often

***5. I have felt scared of panicky for no very good reason**
- ❑ Yes, quite a lot
- ❑ Yes, sometimes
- ❑ No, not much
- ❑ No, not at all

***6. Things have been getting on top of me**
- ❑ Yes, most of the time I haven't been able to cope well
- ❑ Yes, sometimes I haven't been coping as well as usual
- ❑ No, most of the time I have coped quite well
- ❑ No, I have been coping as well as ever

***7. I have been so unhappy that I have had difficulty sleeping**
- ❑ Yes, most of the time
- ❑ Yes, sometimes
- ❑ Not very often
- ❑ No, not at all

***8. I have felt sad or miserable**
- ❑ Yes, most of the time
- ❑ Yes, quite often
- ❑ Not very often
- ❑ No, not at all

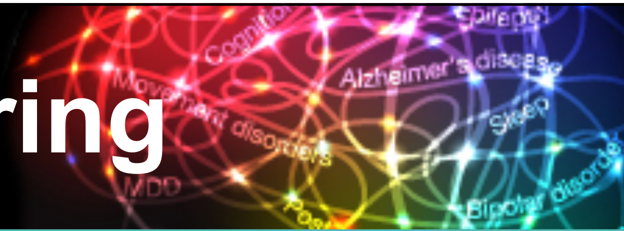
***9. I have been so unhappy that I have been crying**
- ❑ Yes, most of the time
- ❑ Yes, quite often
- ❑ Only occasionally
- ❑ No, never

***10. the thought of harming myself has occurred to me**
- ❑ Yes, quite often
- ❑ Sometimes
- ❑ Hardly ever
- ❑ Never

*questions are reverse scored

Cox JL, et al. *Br J Psychiatry.* 1987;150:782-786.

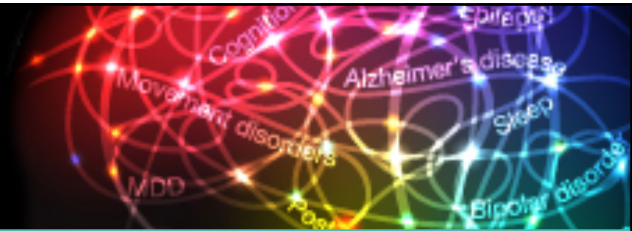
Screening Tool: EPDS scoring



- Questions 1, 2, & 4
  - Are scored 0, 1, 2 or 3 with top box scored as 0 and the bottom box scored as 3
- Questions 3, 5-10
  - Are reverse scored, with the top box scored as a 3 and the bottom box scored as 0
- Maximum score: 30
  - Positive depression: 10 or greater
  - Always look at item 10 (suicidal thoughts)

Cox JL, et al. *Br J Psychiatry.* 1987;150:782-786.

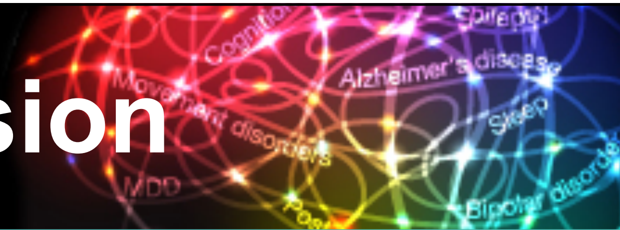
Pearls for Pregnancy



- Reproductive age women on psychiatric treatment should be counselled about use of birth control if not planning on becoming pregnant
- Avoid valproate, carbamazepine, paroxetine, and benzodiazepines in pregnancy (stop if pregnancy occurs while taking; change if planning pregnancy). Start folate and prenatal vitamins
- Consider lamotrigine, risperidone, quetiapine, sertraline, bupropion, buspirone, fluoxetine for MDD or bipolar depression during pregnancy
- Consider fetal echocardiogram for fetus exposed to lithium or paroxetine in first trimester

ACOG Committee. *Obstetrics & Gynecology*. 2008;111(4):1001-1020.

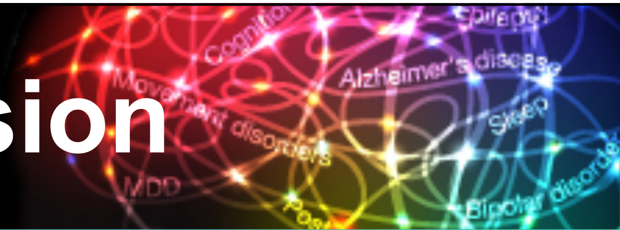
Pearls in Perinatal Depression



- If stopped antidepressant due to pregnancy and depression recurs (70%), restart previously effective medication (past history guides treatment)
- If never treated before, start fluoxetine during pregnancy unless she plans to breastfeed, then use sertraline (most data available)
- Maximize the use of one medication as opposed to polypharmacy (impact on fetus is not dose-related)
- Likely need to increase dose through pregnancy due to increased metabolism and increased volume of distribution

McAllister-Williams RH, et al. *J Psychopharmacol*. 2017;31(5):519-552.

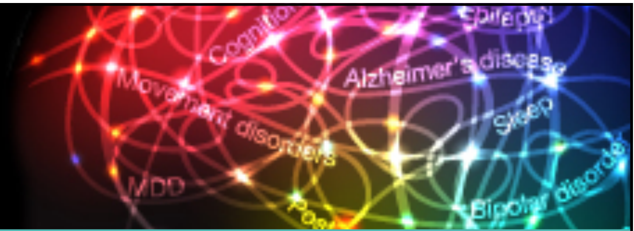
Pearls in Perinatal Depression



- Screen for PPD
- Remission is the goal
  - Risks of exposure not dose-related
  - Avoid exposure to both drug and continued depression
    - treat to remission
  - Do not reduce dose or stop antidepressant in third trimester
  - May be able to decrease dose after delivery, but not stop. Treat for full 12 months in remission

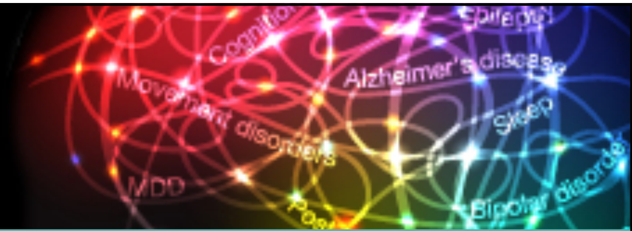
ACOG Committee. *Obstetrics & Gynecology*. 2008;111(4):1001-1020; Stuart-Parrigon K, et al. *Curr Psychiatry Rep*. 2014; 16(9):468.

Pearls for Postpartum



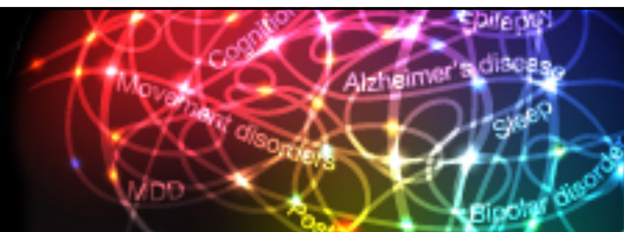
- Plan in advance if prior episode
- Make special considerations if previously treated
- Psychotherapy effective alone or with meds
- ECT may be used

Case for Discussion



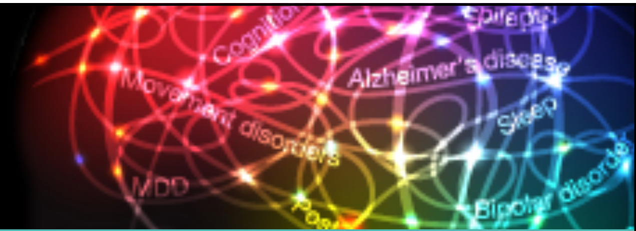
- 30-year-old married woman 28 days S/P uncomplicated vaginal delivery of her first child, a daughter
- Presents with complaints of severe anxiety up to panic at times, self-blame, feeling like a complete failure as a mother, low mood, crying episodes, sleep disturbance, and low energy for the last 3 weeks. She denies thoughts to hurt herself or her child, but is unreasonably fearful for her child's safety
- No prior history of depression, healthy, no chronic meds
- Family history of MDD in mother – treatment unknown
- Has significant local family supports in spouse, parents and in-laws and other extended family
- Is a college graduate and working full-time until 6 weeks ago

Conclusions



- Risk/benefit ratio is critical in treatment of depression during pregnancy and postpartum depression
- Current treatment options for PPD are similar to treatment for MDD outside the postpartum period
- Emerging therapies with new MOA and rapid onset are in development

Call to Action



- In the perinatal period:
  - Utilize the EPDS for screening, to follow through the pregnancy and beyond, and to monitor for remission
- In the postnatal period:
  - Plan in advance if prior episode
  - If previously treated:
    - Use medication that was effective
    - Start on the day of delivery
    - Do not withhold treatment due to breastfeeding – self-tapering will occur with weaning.
      - Monitor baby for adverse effects from exposure through breast milk

Questions & Answers

Don’t forget to fill out your evaluations to collect your credit.