Postpartum Depression: Risk Factors and Treatment Options

October 01, 2004 | Depression [1], Major Depressive Disorder [2], Addiction [3]
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The postpartum period represents a time of increased vulnerability for women, though postpartum disorders are often under-recognized and undertreated.

Lifetime prevalence rates of major depressive disorder (MDD) in women are estimated to be as high as 21% (Kessler et al., 1993; Weissman et al., 1993). The postpartum period in particular represents a time of increased vulnerability for women (Cox et al., 1993; O'Hara et al., 1990), though postpartum disorders are often under-recognized and undertreated. Pregnant women generally receive little education about the possibility of depression after delivery, and because symptoms of depression can overlap with common postpartum symptoms, they may go unrecognized. Women may also feel ashamed of having negative emotions at a time when they "should be joyful" and thus not seek professional help.

The DSM-IV defines postpartum depression as a major depressive episode with an onset in the first four weeks following childbirth. Although epidemiologic studies vary in the time frame used to define the postpartum period, ranging from four weeks to six months after delivery, the period of increased risk seems to occur relatively close to delivery. A study by Cox et al. (1993) of 232 postpartum women found that rates of depression were threefold higher in the five weeks after giving birth, but comparable at six months postpartum, when compared to a similarly matched control group of women who had not had a baby within the last 12 months. Wisner et al. (2004a) found that in 51 nondepressed women with a history of postpartum depression, 21 women developed a recurrent postpartum episode when followed for the year after childbirth. Five (24%) of these women experienced depression in the first postpartum month.

Postpartum depression should be distinguished from postpartum blues (commonly known as the baby blues), a relatively common condition that can affect 50% to 80% of women and is characterized by emotional lability, irritability, anxiety and sleep disturbance that usually resolves within two postnatal weeks. Treatment for postpartum blues includes reassurance and validation of the woman's experience, as well as assistance in caring for herself, the home and the baby. However, follow-up of women with postpartum blues is important, as up to 20% go on to develop postpartum depression (Stowe, 1996).

Postpartum depression is the most common psychiatric disorder that occurs in the puerperium, and it affects approximately 10% to 15% of women. Women without a history of major depression have a 10% risk of developing postpartum depression, though the risk of depressive symptomatology may be higher (O'Hara et al., 1990). With a history of major depression, the risk for postpartum depression rises to 25%, and with a history of a prior postpartum depression, the risk of recurrence rises further to 50% (Garvey et al., 1983; O'Hara, 1995). In addition to prior history of depression or postpartum depression, other risk factors for developing a postpartum depression include the following (Beck, 1996; Gotlib et al., 1991; Marks et al., 1992; O'Hara, 1986; Zelkowitz and Milet, 1996):

- depressive symptoms during pregnancy
- family history of depression
- marital difficulties
- ambivalence about the pregnancy
- limited social support and stressful life events.

Symptoms of postpartum depression are consistent with those of major depression that occurs at any other time in a woman's life, though women suffering from postpartum depression often have marked anxiety (Hendrick et al., 2000) and a tendency to ruminate or even obsess over the health and well-being of the baby. Other features associated with postpartum depression include lower incidence of suicidality (Pitt, 1968) and more difficult social adjustment (O'Hara et al., 1990), when compared to MDD. Although symptoms of postpartum depression can be quite distressing, they are
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Published on Psychiatric Times
(http://www.psychiatrictimes.com)

often missed due to preoccupation with the baby or because the symptoms are attributed to the natural stress of caring for a newborn. Since sleep disturbances, appetite and weight changes, and fatigue are common to the postpartum period, the Edinburgh Postnatal Depression Scale (EPDS) (Cox et al., 1987), which focuses on nonsomatic symptoms, is a useful screening instrument for postpartum depression. A thorough evaluation is also important, as failure to address even subsyndromatic symptoms can result in progression to a major depressive episode and/or cause impairment in psychosocial functioning and interactions with the infant.

Hormonal Factors
Dramatic hormonal changes occur during pregnancy and shortly after childbirth, and a number of studies have investigated the contribution of reproductive events to the occurrence of postpartum mood disorders. Estrogens, progesterone, β-endorphin, human chorionic gonadotropin, prolactin and cortisol levels rise during pregnancy, reaching maximum levels near term and declining sharply after birth. To date, studies of these biologic factors have not identified a specific etiologic link between reproductive changes and postpartum mood disorders (Hendrick et al., 1998). Nevertheless, women who develop postpartum depression may be especially sensitive to these reproductive changes. Oxytocin, which rises sharply at delivery to stimulate uterine muscle contraction and promote the release of breast milk, has not been studied in relationship to postpartum depression.

Abnormalities in postpartum thyroid function have also been postulated as contributing to postpartum mood disturbance. Rates of postpartum hypothyroidism are relatively high in the first six months after childbirth, with the rate of thyroiditis reaching 9%, compared to 3% to 4% in the general population (Goldman, 1986). While thyroid dysfunction does not seem to account for most cases of postpartum depression, it may play a role for a subgroup of women. In a prospective study of 303 pregnant euthyroid women, postpartum thyroid dysfunction developed in 21 women (7%) (Pop et al., 1991). Of these 21 women, 38% had postpartum depression that resolved with treatment of the thyroid abnormality. Thus, thyroid dysfunction should be considered in the evaluation of a woman who presents with postpartum depression.

Untreated Depression
Untreated postpartum depression may impact maternal functioning, mother-infant bonding and family functioning. Mothers who are depressed are at risk for compromised emotional responsiveness to their babies, though maternal behavior varies and maternal depression may not have a singular effect on the infant (Weinberg and Tronick, 1998). Some mothers with depression are disengaged and withdrawn when interacting with their infants, while others can be intrusive, displaying anger and interference. Other mothers are able to mobilize themselves sufficiently to interact positively with their infants (Cohn and Tronick, 1989; Weinberg and Tronick, 1998). Maternal behavior may be influenced by variables such as severity of depression and infant temperament. Nevertheless, maternal depression has been associated with adverse effects on infant attachment and behavior (Murray, 1992; Stein et al., 1991) as well as cognitive development (Cogill et al., 1986).

In a review of the literature, Grace et al. (2003) found that the adverse effects of postpartum depression tend to be greater when the depressive episode is severe and prolonged and when it occurs in the context of adversity. They also found that chronic or recurrent maternal depression is more likely to be related to subsequent effects on the child. These findings underscore the importance of early recognition and treatment of postpartum depression.

Treatment Options
The treatment of postpartum depression is multifactorial and includes reassurance, suggestions for increased help around the home, psychoeducation, and, in some cases, psychotherapy and/or pharmacologic treatment (Altshuler et al., 2001). Individual psychotherapy can be an essential part of treatment, especially for women with difficulties adjusting to motherhood and/or fears about new responsibilities. Including a woman's partner in at least one or two meetings can be useful for providing information as well as support. For mothers who find themselves feeling isolated, group psychotherapy may also be helpful.

Psychotherapy treatment studies of postpartum depression have demonstrated the efficacy of interpersonal psychotherapy (IPT). A prospective study by O'Hara et al. (2000) of 120 postpartum women with major depression randomly assigned to 12 weeks of IPT versus a waiting list condition control group found that subjects receiving IPT had significantly greater reduction in depressive symptoms and improvement in social adjustment. Thus, IPT may present an alternative form of treatment to pharmacotherapy, especially for women who are nursing.

Pharmacologic treatment studies for postpartum depression are limited and include one double-blind study demonstrating efficacy of fluoxetine (Prozac) or cognitive-behavioral therapy for major or minor depression (Appleby et al., 1997); one open study each for sertraline (Zoloft), venlafaxine (Effexor) and fluvoxamine (Luvox) (Cohen et al., 2001; Stowe et al., 1995; Suri et al., 2001); and one double-blind, placebo-controlled preventive study for sertraline (Wisner et al., 2004b). Approximately 60% of mothers initiate nursing, and most antidepressants are excreted into breast milk. The
majority of reports have not described adverse behavioral effects in nursing infants exposed to antidepressants. In a recent analysis of the available data, Weissman et al. (2004) identified 57 studies of maternal plasma, breast milk and/or infant plasma antidepressant levels from nursing mother-infant pairs. They concluded that sertraline, paroxetine (Paxil) and nortriptyline (Aventyl, Pamelor) may be the preferred choices for nursing women. However, the total number of cases reported for any given medication is small, and concern for infant safety must be considered.

Conclusion
The few months after childbirth represent a time when women may be vulnerable to experiencing postpartum depression. Women should be followed during this period, especially if they have a history of depression or depressive symptoms during pregnancy. Treatment should be multifactorial, including consideration of psychosocial as well as pharmacologic options. Adequate recognition and treatment of postpartum depression is essential to the health and well-being of the mother, the infant and the family.

References:


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