Postpartum Depression:
Comforting Kate

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Kate's Case

Kate, 27, presents with a four-week history of:

- sad mood,
- sleep impairment in the form of terminal insomnia,
- loss of appetite with weight loss,
- lack of energy,
- poor concentration and
- feelings of guilt.

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According to the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Text Revision (DSM-IV-TR), postpartum depression (PPD) is defined as an episode of major depression with onset of symptoms within four weeks after delivery.

In general, the clinical features of PPD are similar to the symptoms of non-postpartum depression and may include panic attacks, obsessions and excessive worrying. PPD must be differentiated from other forms of mood disturbance after delivery, including the postpartum blues and postpartum psychosis.

The postpartum blues are quite common within the first week to 10 days after delivery and are characterized by transient symptoms, such as crying, sadness, anxiety, irritability and mood lability. Postpartum psychosis, on the other hand, constitutes a psychiatric emergency due to risk of suicide and infanticide. Typically, the symptoms include delusions, hallucinations, confusion and disorganized behaviour.

How should screening and diagnostic evaluation be approached?

It is important to identify women who are at an elevated risk of developing PPD. The most commonly used screening instrument is a 10-item, self-report questionnaire known as the Edinburgh Postnatal Depression Scale.[1] Each item is scored on a four-point scale from zero to three, yielding a maximum score of 30. A cut-off score of 13 or higher signifies the presence of depressive symptoms. Screening instruments, however, are not a substitute for a thorough diagnostic interview aimed at eliciting information about safety issues, psychiatric and physical co-morbidity and personal and family history of depression and functional impairment.

FAQ

Should antidepressants be used while breastfeeding?

All antidepressants are excreted in breast milk. Antidepressants are relatively safe to use in mothers who decide to breastfeed. The lowest effective dose of antidepressants should be used to minimize drug exposure to the baby. Close monitoring of the infant for possible effects is recommended.[2]

More on Kate

Kate is reluctant to try an antidepressant due to the fear that the antidepressant excreted in breast milk might harm the baby.

However, following a discussion about the use of antidepressants during lactation, she reluctantly agrees to take sertraline, 150 mg a day.

Thyroid function should be assessed to rule out hypothyroidism and hyperthyroidism, both of which can be associated with mood symptoms. Since the postpartum period is a high-risk period for the onset or exacerbation of bipolar disorder, women with PPD should be asked about symptoms of (hypo) mania.[3] Postpartum psychosis can begin with rather vague mood symptoms during the prodrome; therefore, it is also vital to rule out psychosis.

FAQ

Are women with PPD at risk for further recurrences?

The risk of postpartum and non-postpartum recurrences of depression is increased in women with postpartum depression (PPD). The magnitude of the risk depends on the polarity of the mood disorder and whether the PPD follows the first or a subsequent delivery. In one study of women with bipolar disorder, the recurrence rate of postpartum relapse was 100% if the first delivery was followed by depression, compared with a rate of 46% if the first episode of depression occurred after a subsequent delivery.[4] Another study showed a one-year recurrence rate of 41% in women who had at least one episode of PPD.[5]

FAQ

How do I identify women at risk of having an episode of PPD?

Several biologic and psychosocial risk factors have been identified. The strongest risk factors include the presence of anxiety or depression during pregnancy, personal and family history of major depression or bipolar disorder, stressful life events and lack of social support.

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How should patients be treated?

The choice of treatment modality depends on symptom severity, response to treatment during previous episodes, patient preference and polarity of the disorder (*e.g.*, major depressive disorder versus bipolar disorder). Various non-biologic interventions, including cognitive therapy and interpersonal psychotherapy, have been studied in the treatment of PPD.

Pharmacologically, a selective serotonin reuptake inhibitor, such as fluoxetine, paroxetine or sertraline, or a serotonin-norepinephrine reuptake inhibitor, such as venlafaxine, is generally recommended as the first-line treatment. The usual duration of treatment is a minimum of six months, following a full resolution of depressive symptoms; however, patients with a history of recurrent depression should be considered for prophylactic use of medication for the prevention of recurrences.

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