

Stonebriar Psychiatric Services News & Views

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Ages Served

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Yes, Tom, It Really Does Exist...

Not long ago, a certain Hollywood celebrity was making claims that postpartum depression really does not exist and therefore does not require treatment with medication or any other treatment modality available. Another celebrity adamantly maintained that it does and that treatment is not only necessary but vital for mother and child. Guess which one has had a baby and has experienced postpartum depression firsthand.

The fact of the matter is that postpartum changes in mood are relatively common, and in certain forms can be potentially life-threatening to the mother or the child. It has been clearly shown that mothers are vulnerable to mood disorders during the first six months following childbirth. However, the severity and potential consequences of this mood disorder can vary significantly depending upon the form it takes. It is also not clear whether these represent different disorders or perhaps a continuum of mood disorder syndromes.

Postpartum Blues

Postpartum blues occur in up to 85% of all new mothers, generally begins within the first 2-4 days after delivery, peaks around days 5-7, and tends to resolve by day 12-14 postpartum. The symptoms generally include irritability, emotional hypersensitivity, and mood lability. It has been hypothesized that the sudden hormonal changes that occur with childbirth may play a role in its development, and obstetric complications do not seem to increase the risk for postpartum blues. Postpartum blues may go on to develop into postpartum depression in approximately 20% of cases, with the risk being increased in women with a family or personal history of depression, symptoms of depression during pregnancy, or a history of premenstrual dysphoria, sometimes known as "PMS." With uncomplicated postpartum blues, support and reassurance that this is a common occurrence and tends to resolve over several days is often all that is needed. Because mothers are often discharged from the hospital before its onset, prior education about postpartum blues is helpful.

Postpartum Depression

In general, postpartum depression tends to begin later than postpartum blues and occurs in approximately 12-13% of postpartum women, which is approximately equal to the rate of depression in the general female population. However, it is known that a higher percentage of women may exhibit rather difficult subclinical depressive symptoms which do not fully meet the criteria for major depression. Official nomenclature would designate postpartum depression as a *major depressive disorder with postpartum onset* with it generally occurring within four weeks of childbirth. Unfortunately, because of the increased focus on the newborn, the mother often may not present for treatment until after the third postpartum month.

The etiology of postpartum depression is still not clear. There is some evidence that it may relate to hormonal changes and that certain women may be more predisposed to the influence of these hormonal changes. We do know that postpartum depression may increase the risk of negative parenting behaviors, which can place the child at increased risk for delayed or abnormal social, emotional, and behavioral development. If untreated, it may also develop into a chronic maternal depression affecting both mother and child. Studies have indicated that when compared to children of nondepressed mothers, children of depressed mothers may have difficulty regulating their emotions, may have an increased likelihood of being aggressive toward parents and peers, and tend to have some impairment in social competence and relationships. Breast-feeding infants of depressed mothers tend to gain less weight, possibly because of the adverse effect of depression upon the mother's diet. The important point is that evidence suggests that prompt treatment of maternal depression can help prevent or correct many of these problems for the child.

Risk factors for developing postpartum depression include having a prior history of major depression or having been depressed during the pregnancy. A prior episode of postpartum depression raises the risk of recurrence to approximately 50%. The risk is also increased in women with a history of premenstrual dysphoria, past emotional dysphoria occurring with oral contraceptives, a family history of mood disorders, psychosocial stress and/or a dysfunctional marital relationship, inadequate social support, or stressful life experiences during pregnancy.

A woman with postpartum depression generally experiences severe anxiety, often related to worrying about their baby's health or their ability to be a competent

mother. They frequently experience poor appetite, decreased concentration, and often feel emotionally and physically exhausted and unable to sleep. In its most severe form, she may be unable to care for herself or her infant or may be at risk for suicide. It should be stressed that *nonpsychotic* postpartum depressed women may have suicidal thoughts but are *not likely* to harm their babies. They also experience feelings of guilt and inadequacy regarding their ability to be a good mother.

Treatment of postpartum depression, as with other major depressive disorders, generally requires antidepressant medication along with education, psychotherapy, psychosocial support, and often referrals to self-help programs or national support organizations when available. For those with a history of postpartum depression, it has been suggested that beginning antidepressants within the first 1-2 days following delivery may reduce the risk of recurrence. Many of the antidepressants, particularly the SSRIs, have generally been found to be safe with mothers who are breast-feeding. For those needing regular benzodiazepines to help with extreme anxiety, mood stabilizers and/or antipsychotics (see below), it is probably best for the mother to not breast-feed. Electroconvulsive therapy (ECT) may be considered for those with marked suicidal ideation or psychotic symptoms and particularly when maternal or infant health is compromised and more rapid resolution of symptoms is needed.

Postpartum Psychosis

Postpartum psychosis represents a psychiatric emergency and affects 1-2 women per thousand births. Onset tends to be rapid and generally occurs within the first two or three days following delivery. As has been noted in past nationally publicized tragedies, infanticide can occur and is estimated to be approximately 1 in 50,000. Clinically, there tend to be prominent mood swings, at times from depression to mania (see previous newsletters regarding bipolar disorder), severe agitation, confusion and disorientation, hallucinations and at times delusions, and frequently extreme sleep impairment. Postpartum psychosis is considered by many to be a variation of bipolar disorder, and its occurrence represents a significant risk for future non-postpartum relapses.

Risk factors for developing postpartum psychosis include a prior history of bipolar disorder. Some studies indicate that the risk for postpartum psychosis is almost 100 times greater when there is a prior history of bipolar disorder, with the incidence ranging from 26-35%. Women with a prior history of both postpartum psychosis and bipolar disorder have a 38-50% risk of having another postpartum psychosis following delivery. Conversely, it is also felt that a significant postpartum depression, and particularly postpartum psychosis, may be the first manifestation of subsequent bipolar disorder.

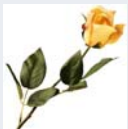
Postpartum psychosis can be associated with significant child neglect or abuse, even to the point of infanticide. Treatment almost always involves hospitalization and often requires mood stabilizers, antipsychotic medication, and benzodiazepines for extreme agitation or anxiety. As with bipolar disorder itself, antidepressants can also be used, but cautiously for fear of triggering increased mood swings. Again, ECT is an option and particularly for postpartum psychosis refractory to other treatments. It is also important to reassure the patient and family that with treatment, these women will generally recover and become effective and loving mothers.

Women with a prior history of bipolar disorder should generally be maintained on a medication regimen which includes a mood stabilizer. When medication is used for a first time postpartum psychosis, the medications may be tapered after a year of stability but should be restarted immediately following future deliveries. We also know that generally it is preferable to maintain mood stability during pregnancy by using appropriate medications than to have a mother off medication and experiencing significant depression or bipolar mood swings. Certainly, there are some medications that are preferable to use during pregnancy than are others, and this decision needs to be discussed with a qualified professional. The same holds true with regard to nursing. We know that all psychotropic medications tend to be excreted to some degree in breast milk. Although there is fairly good evidence regarding the safety of many antidepressants, particularly the SSRIs, while nursing, there is less data concerning the safety of mood stabilizers. For that reason, and because it is also extremely important to maintain relatively stable sleep patterns for individuals with bipolar disorder, it is probably best for most women with bipolar disorder not to nurse their infants. For those that strongly want to nurse, the pros and cons of this decision would need to be explored.

In summary, there is little question in the professional community that postpartum blues, depression, and even psychosis do exist. While they can, and do, represent psychiatric conditions which have potentially significant consequences for both mother and child, they also can generally be effectively treated when recognized. And to those who would say that it is nonexistent, I would suggest that he try it and experience it firsthand before making that claim.



Do you have topical requests for future newsletters? Let us know at: NewsletterQuestions@stonebriarps.com



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