

Be on the lookout for postpartum depression

📌 Q&A on PPD with Susan Hatters Friedman, MD, and Janelle Yates, OBG MANAGEMENT Senior Editor

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As many as 85% of women develop some type of mood disturbance after pregnancy. Most cases resolve spontaneously in a matter of days but, sometimes, the mood disorder is serious. Here's what an authority on the topic advises about how to identify women whose history and presentation merit further assessment and, possibly, treatment.

When to look for it

OBG MANAGEMENT: What is the incidence of postpartum depression?

FRIEDMAN: Depending on the study, the rate reported in the medical literature ranges from 10% to 25%.

OBG MANAGEMENT: When does it develop?

FRIEDMAN: Postpartum depression usually begins weeks to months after delivery. Again depending on the study, the cutoff for diagnosis ranges from weeks after delivery to 1 year after delivery. The first year of the infant's life and, in particular, the first several months after delivery are periods of elevated risk.

OBG MANAGEMENT: Is an obstetrician likely to be one of the first clinicians to encounter the patient after postpartum depression sets in?

FRIEDMAN: Absolutely. The obstetrician sees new mothers at their 6-week postpartum check. The pediatrician sees them at their infant's visits. Both are more likely than a psychiatrist to have the initial encounter with these women. Public health nurses who visit the homes of some

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patients are also in a good position to detect postpartum depression.

Signs and symptoms

OBG MANAGEMENT: What signs suggest depression, as opposed to normal anxiety over becoming a parent?

FRIEDMAN: Difficulty sleeping even when the baby sleeps—that’s a useful question to ask moms—prolonged sadness, feelings of worthlessness, inability to experience joy and happiness, and, of course, suicidal or violent thoughts. Although any new mother might have some normal anxiety, clinicians should become concerned when this anxiety is excessive or obsessive.

OBG MANAGEMENT: Are some types of women more likely to develop postpartum depression?

FRIEDMAN: Women are at higher risk if they have:

- a personal history of depression at any time in their life
- a family history of depression
- certain personality traits, such as avoidance, dependence, and obsessive-compulsive tendencies
- stressful life events
- a lack of emotional support
- sleep deprivation.

How to screen for PPD

OBG MANAGEMENT: Do you think the OB should screen for depression at the postpartum visit?

FRIEDMAN: Absolutely. They are in an opportune situation to do so.

OBG MANAGEMENT: Are there screening tools that can streamline this process?

FRIEDMAN: The Edinburgh Postnatal Depression scale is a well-validated, one-page, 10-question scale that the patient can self-administer in the waiting room. [Editor’s note: See the Scale at www.fresno.ucsf.edu/pediatrics/downloads/edinburghscale.pdf.] The obstetrician should also be aware of referral resources in his or her own community.

OBG MANAGEMENT: If it looks like depression, is it always depression—or could it be bipolar disorder, or something similar? What are distinguishing features?

FRIEDMAN: It isn’t always depression. The differential diagnosis includes:

- **baby blues**—this is a short-lived, self-resolving normative experience that occurs in the first 2 weeks after childbirth; it’s characterized by transient feelings of depression, anxiety, and upset
- **bipolar disorder**—the patient exhibits discrete periods of both depression and mania or hypomania
- **postpartum psychosis**—this condition of relatively rapid onset in the first week or so after childbirth is a psychiatric emergency; it involves psychosis—hallucinations, delusions—and mood symptoms
- **medical causes, or delirium**—these are nonpsychiatric entities that include postop problems; anemia, which causes lethargy; and an abnormal level of thyroid-stimulating hormone.

When to refer

OBG MANAGEMENT: Should an OB always refer a patient when he, or she, detects postpartum depression? Or is prescribing an antidepressant appropriate?

FRIEDMAN: Some OBs feel comfortable prescribing antidepressants; others opt for a one-time psychiatric consult and then medicate. One important matter to consider, however, is loss to follow-up. If an OB sees the patient only at her 6-week checkup and not again until her annual visit, she should be referred out to psychiatry or back to her family physician—if that physician treats depression.

Bipolar disorder needs to be screened for. If a woman has bipolar disorder rather than uncomplicated unipolar depression, then treatment with an antidepressant could precipitate a manic state. The OB should seek out a personal or family history of mania. If there is concern about bipolar disorder, the patient should be referred for evaluation.

If the OB plans to prescribe an antidepressant, lactation status needs to be con-



The differential diagnosis for PPD includes “baby blues,” bipolar disorder, postpartum psychosis, and medical causes

sidered, and an attempt should be made to coordinate with the pediatrician regarding exposure. Many clinicians are comfortable prescribing sertraline during lactation.

OBG MANAGEMENT: Are there any red flags—signs that justify immediate attention?

FRIEDMAN: Any threat or suicidal statement, or excessive anxiety—like frequent phone calls to the office—should be dealt with appropriately.

OBG MANAGEMENT: Anything else that you think is important for an OB to know about postpartum depression?

FRIEDMAN: This entity is something the OB is in an opportune position to notice. Postpartum depression doesn't just cause problems for the mother; untreated, it puts the family unit at risk—of suicide, infanticide, child neglect, and difficulty bonding with the baby. 🚫

Suggested Reading

1. Psychopharmacology throughout the life cycle of women
By Henry A. Nasrallah, MD; SRM eJournal May 2008. Available at: www.obgmanagement.com/srm/pdf/May_2008_Archive/SRM0508_MentalHealth.pdf

IN THE WORKS FOR 2009

Managing your own anxiety:
What can the ObGyn manage
in psychiatry?

BY SUSAN HATTERS FRIEDMAN, MD



Red flags include
a threat, suicidal
statement, or
excessive anxiety