

Postpartum **mood disorders** — A practitioner's guide to **diagnosis and treatment**

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Mood disorders in the postpartum period are now recognised to be a major problem, affecting 10 - 22% of women.^{1,3} A spectrum of mood disorders in the postpartum period is recognised, viz. postpartum blues, postpartum depression, and postpartum psychosis.^{1,2,4}

The differentiation between postpartum blues and depression can be difficult owing to an overlap of symptoms, often leading to underrecognition of the former.^{1,2}

Postpartum blues

The 'blues' is a very common entity in the postpartum period, affecting 50 - 85% of women.² A significant percentage (20%)² of women with postpartum blues go on to develop postpartum depression (Table I).

The treatment of postpartum blues requires education and ongoing support of the patient, with continued evaluation of those at risk of developing postpartum depression.³

Postpartum depression

The diagnostic criteria used for postpartum depression are similar to the *Diagnostic and Statistical Manual (DSM-IV)* criteria (Appendix A) for major depressive episode, with a modifier applying to the postpartum period (onset of episode within 4 weeks postpartum).^{3,5}

The severity of symptoms and deterioration in social and/or occupational functioning can be used to distinguish between

Table I. Comparison between postpartum blues and postpartum depression

Postpartum blues ^{1-3,9}	Postpartum depression ^{5,9}
Symptoms up to 10 days after delivery (should clear up after this period)	Symptoms within 4 weeks of delivery, continuous 2-week period
Symptoms Mood lability Depression Irritability Tearfulness Anxiety Sleep disturbance Appetite disturbance	Symptoms (5 or more of following): Depressed mood Diminished interest or pleasure in ± all activities Weight loss or weight gain Insomnia or hypersomnia Psychomotor agitation or retardation Fatigue or loss of energy Feelings of worthlessness or excessive or inappropriate guilt Diminished concentration or indecisiveness Recurrent thoughts of death or suicidal ideation
Symptoms subside within 10 days of delivery with only supportive intervention	Symptoms persist for longer than 2-week period, affects general functioning and needs medical treatment

postpartum blues and depression (Table I).

Risk factors

Identified risk factors, which may increase the likelihood of post-

Table II. Risk factors^{2,3,6-9}

Personal psychiatric history of mood disorder
Family history of depression
Low levels of social and spouse support
Recent adverse life events
Unwanted pregnancy
Underlying thyroid disease (5% of postpartum women have transient hypothyroidism) ⁹
Adolescent mothers
Marital conflict
Child care-related stressors (feeding, sleep problems, infant's health, and temperamentally difficult infants)

partum depression, are listed in Table II.

Screening scales

It may be difficult for the clinician to decide whether symptoms of depression are due to a period of adjustment after having a baby, or the result of a fully fledged mood disorder. First-time mothers may not recognise that they are depressed — societal pressure may cause reluctance to admit to a problem, owing to shame and fear. Furthermore, new mothers often do not know who to turn to for help.⁹ It is therefore important to identify women at risk and to monitor them closely after delivery.

The Edinburgh Postnatal Depression Scale (EPDS) is currently the instrument of choice for identifying postpartum mood disorders, as it was specifically designed for this purpose.⁹ This scale is an inexpensive, convenient and accurate self-rating screening tool for postpartum depression¹⁰ with high sensitivity (100%) and specificity (95.5%) in detecting major depression.⁹

Basic principles of the Edinburgh Postnatal Depression Scale⁹⁻¹²

The EPDS is a self-report scale measuring symptoms experienced in the previous week (7 days). There are 10 statements related to depressive symptoms, each statement rated from 0 to 3 (0 = no symptoms, 3 = severe symptoms), with a possible total score of 0 - 30. A score of 10 or less identifies women at risk, while a score of 13 or more indicates that the woman is probably experiencing postpartum depression.

Edinburgh postnatal depression scale^{10,13}

The EPDS is ideally administered at 5 - 8, 10 - 14 and 20 - 26 weeks postpartum.¹³

Women are asked to answer all 10 questions, underlining the answer that comes closest to how they have felt over the past 7 days, i.e. not just on that day (Appendix B).

Consequences of non-treatment of postpartum depression

Inadequate treatment of postpartum depression increases the risk of sequelae of untreated mood disorders, i.e. a pattern of chronic depression and recurrent, refractory disease.¹

Non-treatment increases the incidence of postpartum psychotic depression, suicide and infanticide. A higher rate of violent suicide is present among teenage and unmarried mothers.^{3,4}

Depressed mothers display a negative interaction style with their infants and the infants in turn display lower activity levels, tending to be more irritable and to show less positive facial expressions.¹¹

Postpartum depressed mothers show raised levels of hostility towards their infants and fail to acknowledge infant autonomy. A pattern of avoidant child behaviour may be established. By age 5 years, many of these children have developed patterns in which the sense of self agency is reduced and self negation is increased. They also tend to fail to respond to others' social initiatives.¹⁴

An increase in hyperactive behaviour, especially in boys, has been found to be prevalent in children of mothers with postpartum depression.¹⁵

Postpartum psychosis

Postpartum psychosis occurs in 0.2% of childbearing women. The onset is normally within 1 month of delivery and is manic in nature. Early warning signs are inability to sleep, agitation, expansive or irritable mood and avoidance of the infant. Delusions or hallucinations often involve the infant, for example the mother may experience auditory hallucinations, telling her to kill the infant. Postpartum psychosis is a medical emergency as the mother may potentially harm herself or the infant. Most patients are hospitalised and treated with antipsychotics and mood stabilisers.⁹

Treatment options

The approach to the treatment of postpartum depression is similar to the treatment of non-puerperal depression. The welfare of the mother, baby and other children should be a primary concern.

Remedial social factors should be attended to. It is important to involve the woman's partner in emotional and practical support.¹⁶

Pharmacotherapy

Pharmacotherapy may be used alone or in combination with psychotherapy.

Antidepressant treatment

Several studies have demonstrated the efficacy of antidepressant medication in the treatment of major depression. Standard antidepressant doses were found to be effective and well tolerated.¹

Tricyclic antidepressants (TCAs) were prescribed most frequently in the past, although selective serotonin re-uptake inhibitors (SSRIs) are probably better tolerated and may therefore be the first-line treatment of choice. Postpartum depression is often associated with anxiety and agitation. Benzodiazepine treatment should be used only as an adjuvant to antidepressant medication for a short period of time.

The initial dose of antidepressant medication (Table III) should be maintained for 2 weeks, before adjustment is considered. Most patients show improvement in symptoms within 2 - 4 weeks of starting medication. Clinical improvement should be obtained within 6 - 8 weeks of commencing antidepressant treatment.

Patients who are decompensating despite high doses of antidepressant medication or who are not responding adequately should be referred to a psychiatrist.

The optimal duration of treatment should be at least 9 - 12 months (first episode).

Women with postpartum depression often experience disturbing, aggressive obsessional thoughts towards the infant and may respond preferentially to SSRI treatment.¹⁸

Hormonal therapy

No systematic data support the use of progesterone in the treatment of postpartum depression. Oestrogen therapy (either alone

or in combination with antidepressant therapy) has putative efficacy in the treatment of postpartum depression, but further research is needed to confirm this.¹

Prescribing antidepressants during breast-feeding

All antidepressants are secreted in breast-milk, but the (limited) available data suggest that plasma concentrations of TCAs and SSRIs in breast-fed infants are rarely detectable on standard assays.^{9,16} The evidence does not seem to warrant recommendation that the mother stops breast-feeding while taking TCAs or SSRIs in usual doses; however, minimum effective doses are recommended.¹⁶

The risk-benefit ratio of antidepressant therapy while breast-feeding should always be discussed with the mother and her partner and written, informed consent obtained. Risk factors should be taken into account, especially with a past history of major depression. Risk factors in the infant should also be evaluated, such as premature birth or any dysfunction that may impair drug metabolism and clearance. If a decision is made to continue breast-feeding while on antidepressants, mother and baby should be monitored closely for possible unwanted effects.¹⁶

'The mother may feed the infant with previously expressed milk for the first few hours following drug ingestion.'¹⁷

Lithium should be used with caution during breast-feeding. No controlled studies have been done, but infant serum lithium levels may be elevated, causing possible cyanosis, hypotonia and electrocardiogram changes.¹⁷

Benzodiazepines with a long half-life should be avoided because they may accumulate in the blood and can result in sedation and poor feeding of the infant.¹⁷

Psychotherapy

Psychotherapy forms an integral part of the treatment of all mood disorders. It may be considered as single treatment modality for women who are reluctant to take antidepressant medication during breast-feeding, especially for those with milder forms of postpartum depression.^{1,9}

Interpersonal therapy may be particularly useful, as it focuses on the patient's interpersonal relationships and changing roles.^{1,9}

Table III. Dosage, half-life and side-effects of antidepressants commonly used to treat major depression⁹

	Starting dose	Usual daily dose	Possible side-effects
Tricyclic antidepressants (mg)			
Amitriptyline (Tryptanol)	25 - 75	100 - 300	Constipation, sedation, weight gain, orthostatic hypotension, blurred vision, dry mouth
Imipramine (Tofranil)			
Clomipramine (Anafranil)			
Lofepamine (Emdalen)	70	140 - 210	
SSRI (mg)			
Fluoxetine (Prozac)	20	20 - 40	Headache, nausea, diarrhoea, nervousness, sedation, insomnia, tremor
Sertraline (Zoloft)*	50	50 - 150	
Paroxetine (Aropax)*	20	20 - 40	
Fluvoxamine (Luvox)*	50	100 - 300	
Atypical antidepressants (mg)			
Venlafaxine (Efexor)	75	75 - 225	Insomnia, anorexia, nervousness, sustained hypertension
Nefazodone	200	300 - 600	
Mirtazapine	15	15 - 45	Somnolence, nausea, weight gain, raised cholesterol and triglyceride level, agranulocytosis

*Specifically investigated in postpartum major depression.
SSRI = selective serotonin re-uptake inhibitors.

A number of studies have found cognitive behaviour therapy (CBT) to be as effective as fluoxetine in the treatment of postpartum depression.¹⁹

Prevention of postpartum depression and relapse

Gynaecologists, general practitioners and antenatal clinics play an important role in raising awareness of mood disorders in the postpartum period.

Education of patients and their families regarding the signs and symptoms of postpartum depression (pamphlets, posters, video presentations),⁹ should be instituted.

Preventive treatment with antidepressant medication should be considered. It has been found that women who receive preventive antidepressant therapy have a significantly lower rate of recurrence of postpartum major depression.¹⁸

There is no advantage to starting treatment prenatally. To avoid fetal exposure it is suggested that antidepressant treatment should be started directly after parturition.¹⁸

The prophylactic use of hormones has been suggested and in one anecdotal series oestrogen plus testosterone (for lactation suppression) reduced the risk of major depression in the postpartum period.¹⁸

Support groups in South Africa

Support groups in South Africa include the Postnatal Depression Support Group, Tel: 082-882 0072; and the Anxiety and

Depression Support Group (national), Tel: 011-7831474/6, 011-8841797, 0800119283 (toll-free). Also see the following website: www.iup.edu/an/postpartum/

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Appendix A. DSM-IV Criteria for Major Depressive Episode

- A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning. At least one of the symptoms is either: (i) depressed mood; or (ii) loss of interest or pleasure.
- (1) Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g. feels sad or empty) or observation made by others.
 - (2) Markedly diminished interest or pleasure in all, or almost all, activities, most of the day, nearly every day.
 - (3) Significant weight loss or weight gain when not dieting (e.g. more than 5% of body weight in a month) or decrease or increase in appetite nearly every day.
 - (4) Insomnia or hypersomnia nearly every day.
 - (5) Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).
 - (6) Fatigue or loss of energy nearly every day.
 - (7) Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day.
 - (8) Diminished ability to think or concentrate, or indecisiveness nearly every day (either by subjective account or as observed by others).
 - (9) Recurrent thoughts of death (not just fear of dying), recurrent

suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

- B. The symptoms do not meet criteria for a mixed episode.
- C. The symptoms cause clinically significant distress or impairment in social, occupational or other important areas of functioning.
- D. The symptoms are not due to the direct physiological effects of a substance (e.g. a drug of abuse, a medication) or a general medical condition (e.g. hypothyroidism).
- E. Bereavement, i.e. after the loss of a loved one: the symptoms persist for longer than 2 months or are characterised by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms or psychomotor retardation.

Appendix B. Edinburgh Postnatal Depression Scale*

In the past 7 days:	Score
1. I have been able to laugh and see the funny side of things:	
(a) As much as I always do	0
(b) Not quite so much now	1
(c) Definitely not so much now	2
(d) Not at all	3
2. I have looked forward to enjoyment of things:	
(a) As much as I ever did	0
(b) Rather less than I used to	1
(c) Definitely less than I used to	2
(d) Hardly at all	3
3. I have blamed myself unnecessarily when things went wrong:	
(a) Yes, most of the time	3
(b) Yes, some of the time	2
(c) Not very often	1
(d) No, never	0
4. I have felt worried and anxious for no very good reason:	
(a) No, not at all	0
(b) Hardly ever	1
(c) Yes, sometimes	2
(d) Yes, very often	3

5. I have felt scared or panicky for no very good reason:		(d) No, not at all	0
(a) Yes, quite a lot	3	8. I have felt sad or miserable:	
(b) Yes, sometimes	2	(a) Yes, most of the time	3
(c) No, not much	1	(b) Yes, quite often	2
(d) No, not at all	0	(c) Not very often	1
6. Things have been getting on top of me:		(d) No, not at all	0
(a) Yes, most of the time I haven't been able to cope at all	3	9. I have been so unhappy that I have been crying:	
(b) Yes, sometimes I haven't been coping as well as usual	2	(a) Yes, most of the time	3
(c) No, most of the time I have coped quite well	1	(b) Yes, quite often	2
(d) No, I have been coping as well as ever	0	(c) Only occasionally	1
7. I have been so unhappy that I have had difficulty sleeping:		(d) No, never	0
(a) Yes, most of the time	3	10. The thought of harming myself has occurred to me:	
(b) Yes, sometimes	2	(a) Yes, quite often	3
(c) Not very often	1	(b) Sometimes	2
		(c) Hardly ever	1
		(d) Never	0