



## An FP's guide to identifying—and treating—postpartum depression

Certain risk factors and this screening tool can help you identify patients at risk. Cognitive behavioral therapy and SSRIs can provide relief.

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### > THE CASE

Alex T,\* a 23-year-old first-time mom, presented to the family medicine office for her baby's 2-week appointment. When asked how she was doing, she began to cry. She said, "I feel crazy" and indicated that she was feeling down and overwhelmed, and was struggling to bond with the baby. She filled out an Edinburgh Postnatal Depression Scale, a standard postpartum depression (PPD) screen; her score, 15 out of 30, was suggestive of depression. Ms. T had been coming to the practice for the past 3 years and had no significant physical or mental health history. She and the baby did not live with the baby's father, and his degree of presence in their lives varied.

### ○ HOW WOULD YOU PROCEED WITH THIS PATIENT?

\*The patient's name has been changed to protect her identity.

PPD, traditionally defined as depression in the postpartum period for as long as a year after childbirth, is a common, underdiagnosed outcome of both normal and complicated pregnancies.<sup>1</sup> Peripartum depression, which includes PPD and depression during pregnancy, occurs in approximately 10% of pregnancies.<sup>2,3</sup> When depression first appears in the postpartum period, most women develop symptoms in the first month after delivery (54% of cases) or in the next 2 to 4 months (40%).<sup>4</sup>

The most significant risk factor for PPD is previous depression, peripartum or otherwise.<sup>1,4-6</sup> Other common risk factors include major life events or stressors during or after pregnancy, domestic violence, poor social support, and preterm birth or an infant admission to the neonatal intensive care unit.<sup>1,7</sup> Women

with a self-perceived negative birth experience are also likely to experience PPD.<sup>8</sup> PPD can be associated with significant morbidity and mortality, with suicide a more common cause of maternal mortality than either hemorrhage or hypertensive disorders of pregnancy.<sup>9</sup>

Early diagnosis and intervention are crucial to improving patient outcomes. Women with PPD initiate breastfeeding at lower rates and continue for shorter durations.<sup>10</sup> PPD also affects maternal-infant bonding; may adversely affect an infant's social, cognitive, and language development; and may lead to attachment disorders of infancy.<sup>11,12</sup> In severe cases, it can lead to failure to thrive or infanticide.<sup>11</sup>

**■ When to screen.** The US Preventive Services Task Force (USPSTF) recommends clinicians screen for depression in pregnant and

➤ **Women with postpartum anemia and low ferritin stores are more prone to depression than are those with normal levels.**

postpartum women (Grade B<sup>a</sup>) and for women at increased risk, provide or refer to counseling interventions (Grade B<sup>a</sup>).<sup>13,14</sup> The American College of Obstetricians and Gynecologists (ACOG) recommends screening at least once in the postpartum period.<sup>15</sup> Repeat screening at follow-up in the later postpartum period increases the likelihood of diagnosis.<sup>16</sup> Screening for PPD as part of well-child care improves maternal outcomes, and the American Academy of Pediatrics recommends screening at the 1-, 2-, 4-, and 6-month visits.<sup>11,17</sup> These screens are separately billable. Family physicians are uniquely suited to screening at both well-child and postpartum visits, as many women share a medical home with their child, and those who do not are equally willing to receive medical advice from their child's physician.<sup>18</sup>

## IS IT "THE BLUES" OR SOMETHING ELSE? DIAGNOSING PPD

Many new mothers experience postpartum blues, which manifest as tearfulness, insomnia, irritability, and anxiety. The postpartum blues, however, don't meet the criteria for major depressive disorder and typically resolve within 14 days of delivery.<sup>19-21</sup> On the other end of the spectrum is postpartum psychosis, which is severe and rare, and can also affect new mothers.

■ **Screening for PPD.** The most commonly used screening tool for PPD is the Edinburgh Postnatal Depression Scale (EPDS 10), a free 10-item instrument scored out of 30 possible points, with any score  $\geq 13$  suggesting PPD.<sup>22</sup> The EPDS 10 has a sensitivity of 74% and specificity of 97% for the diagnosis of PPD.<sup>23</sup> Other screening options include the Beck Depression Inventory II (BDI-II) and the Patient Health Questionnaire 9 (PHQ-9). The 21-item BDI-II takes longer to perform and is less sensitive (57%) than the EPDS.<sup>1</sup> The PHQ-9, which asks about some symptoms common to the postpartum period (including sleep changes), is less specific than the EPDS (sensitivity, 75%; specificity, 90%).<sup>1</sup> The EPDS also includes screening questions about anxiety.<sup>1</sup>

A positive depression screen, or any posi-

<sup>a</sup> There is high certainty that the net benefit is moderate, or there is moderate certainty that the net benefit is moderate to substantial.

tive response to a question on suicidal ideation, should be followed up for confirmation using the *Diagnostic and Statistical Manual of Mental Disorders 5th Edition (DSM-5)* criteria for major depressive disorder with peripartum onset.<sup>24</sup> Women with PPD should also be asked about current or prior symptoms of bipolar disorder or mania.<sup>25</sup> Up to 67% of women with bipolar disorder may relapse postpartum, and they also have an elevated risk of postpartum psychosis.<sup>26</sup> The Mood Disorder Questionnaire is a useful tool if a concern for bipolar depression arises.<sup>27</sup>

Refer any woman in whom bipolar depression is a concern to a clinician experienced with its management. The presence of auditory or visual hallucinations should also be assessed as indicators of postpartum psychosis. Active suicidal or homicidal ideation and postpartum psychosis all require emergent psychiatric care.<sup>21,22</sup> Intimate partner violence may also exist or escalate in the postpartum period and may exacerbate PPD. Both ACOG and the USPSTF recommend screening postpartum women for intimate partner violence.<sup>28,29</sup>

■ **Also consider possible medical causes of PPD symptoms.** Hypothyroidism in the postpartum period may manifest with some similar symptoms to PPD and is commonly underdiagnosed.<sup>22,30</sup> Women with postpartum anemia and low ferritin stores also have a higher likelihood of PPD (odds ratio, 1.7-4.64), and postpartum iron supplementation may reduce this risk (number needed to treat = 4 in at least 1 randomized controlled trial).<sup>31</sup> When anemia is present, ensure that it is properly treated.

## STEPS YOU CAN TAKE TO MANAGE PPD

Refer any woman who has PPD to a qualified therapist whenever possible. Generally, the psychological recommendations for treatment of PPD are very similar to recommendations for general treatment of depression. Psychotherapy on its own is considered a first-line treatment for mild-to-moderate PPD, and medication plus psychotherapy is considered first-line treatment for severe PPD.<sup>32</sup> (Worth noting: It may also be useful to offer counsel-

ing to a patient who appears distressed, even if she does not fully meet all *DSM-5* criteria.)

Of the psychotherapy options, cognitive behavioral therapy (CBT) is supported by the most evidence. There is also evidence for the use of interpersonal therapy (IPT), especially in higher socioeconomic status populations.<sup>33</sup> Key therapeutic targets in IPT are increasing behavioral engagement (eg, reaching out to friends), decreasing negative self-talk (eg, “I am a bad mother”), and negotiating roles and support (eg, both mom’s and family members’ expectations of new motherhood). There is mixed evidence for recommending exercise as a treatment for PPD.<sup>32,34</sup> However, as exercise is a low-risk intervention, you may choose to make that recommendation to patients. Additionally, including partners/support people in treatment/visits for PPD has been shown to increase positive outcomes.<sup>35</sup>

■ **When medication is considered**, selective serotonin reuptake inhibitors (SSRIs) are most commonly used. Research indicates that SSRIs are significantly more effective than placebo for treatment of women with PPD.<sup>36</sup> Sertraline, in particular, has shown to be both effective in treating PPD and safe in lactation.<sup>37,38</sup> Dosing and duration of therapy are equivalent to treatment of major depression outside the perinatal period. Consult a trusted source on medications in lactation before prescribing any antidepressant to a breastfeeding mother. One resource is the National Institutes of Health drugs and lactation database (LactMed; [www.ncbi.nlm.nih.gov/books/NBK501922/](http://www.ncbi.nlm.nih.gov/books/NBK501922/)), which provides detailed information on the levels of medications in breastmilk and their potential effects on an infant.

Women with severe, refractory PPD may require hospitalization. Additional treatment options for women with severe, refractory PPD include electroconvulsive therapy or the new medication brexanolone, which is administered as a 60-hour continuous infusion.<sup>39,40</sup>

## ▶ THE CASE

Further conversation with Ms. T revealed that she met the criteria for PPD (major depressive disorder with peripartum onset). She denied suicidal or homicidal ideation and was not experiencing any symptoms of psychosis. A complete blood count was drawn and showed no

anemia, and her thyroid-stimulating hormone level was within normal limits. She had a good support network at home, with both her mom and sister taking shifts to help her get some extra rest and allow her to attend medical appointments. She said there was no domestic violence.

Ms. T was introduced to the clinic’s embedded counselor, who scheduled a follow-up appointment within the week to start CBT. After a discussion of risks and benefits, Ms. T also started a low dose of sertraline once daily. At follow-up postpartum visits, she reported significant improvement in her mood. She and her physician decided to taper her SSRI medication at 3 months postpartum. Screens for depression at her infant’s 4- and 6-month well-child visits in the office were reassuringly negative.

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