Peer Support Cuts Risk of Postpartum Depression

Mothers who received a telephone-based intervention were two times less likely to become depressed.

BY KATE JOHNSON
Montreal Bureau

MONTREAL — Mother-to-mother support can significantly reduce the development of postpartum depression in women who are at high risk for the condition, Cindy-Lee Dennis, Ph.D., said at the annual conference of the Canadian Psychiatric Association.

"Meta-analyses and predictive studies have clearly suggested the importance of psychosocial variables in the development of postpartum depression," said Dr. Dennis of the Lawrence S. Bloomberg Faculty of Nursing at the University of Toronto.

"When we look at support variables in particular, it's the lack of a confidante that places the mother at risk for postpartum depression," she noted.

Her study involved 701 women who were less than 2 weeks post partum and considered to be at high risk for developing postpartum depression based on an Edinburgh Postnatal Depression Scale (EPDS) score of greater than 9.

The women were randomized to a control group (n=352), which received usual postpartum care, or an intervention group (n=349) that received usual postpartum care plus telephone peer support. A total of 205 peer support volunteers, all of whom had recovered from self-reported postpartum depression, were recruited from the community through fliers and advertising. They were given a 4-hour training session and then matched to the new mothers based on health region, and, if the mother desired, on ethnicity.

For the primary outcome measure, an EPDS score of greater than 12, the study found a significant benefit to peer support. "Mothers who received the intervention were two times less likely to develop postpartum depression," said Dr. Dennis, who reported an incidence of 13.5% in the intervention group and a 26% incidence in the control group.

A secondary outcome measure of anxiety also favored the intervention, with incidences of 20.6% in the intervention group and 26.9% in the control group. "This is bordering on statistical significance, but we think it is clinically relevant and suggests anxiety might be relieved with peer support," she said. There were no differences between the groups in their reports of loneliness.

Predictors of a baseline EPDS score of greater than 12 included non-Canadian ethnicity (reported by 19% of participants), not having been born in Canada (reported by 41% of participants), new immigrant status with less than 5 years in Canada (reported by 43% of those not born in Canada), and no family support (reported by 12% of participants). A total of 59% of the participants were primiparous, 31% had a history of depression, 18% had no other mother to talk to, and almost 10% were very unhappy with the baby's father.

"Because this was a prevention trial, we felt it was unethical to leave a depressed mother in the community. So we administered the SCID [Structured Clinical Interview for DSM Disorders), and if they were diagnosed with clinical depression or had an EPDS score greater than 20, then we referred them back to the public health department and public health did follow up with them," said Dr. Dennis. ■

Older Women's Depression Burden Heavier Than Men's

BY MARY ANN MOON
Contributing Writer

The burden of depression is disproportionately higher among older women than older men because of their greater susceptibility to depression and—once depressed—their greater tendency to have persistent depression and their lower probability of death, suggest the results of a longitudinal study.

Clinically significant depressive symptoms affect 8%-20% of community-dwelling older people, and previous research has failed to explain the underlying gender differences, wrote Lisa C. Barry, Ph.D., of Yale University, New Haven, Conn., and her associates.

This finding 'is somewhat surprising because women are more likely than men to receive pharmacologic and nonpharmacologic treatment for depression.'

They assessed those differences in the onset and persistence of depression, as well as in overall mortality. They used data from a 1998 longitudinal study of 754 residents of New Haven aged 70 years and older at baseline. The subjects were followed using detailed in-home assessments every 18 months for up to 6 years (Arch. Gen. Psychiatry 2008;65:172-8).

At baseline, the subjects were a mean age of 78 years. Sixty-five percent of them were women, and 91% were non-Hispanic whites. On average, subjects had a high school education, had two chronic conditions, and were cognitively intact.

A total of 269 subjects (36%) had depressive symptoms at some time during the 6-year study. The prevalence of depressive symptoms was substantially higher in women than men at all time points.

Compared with men, women had a higher rate of making the transition from nondepressed to depressed status over time, a higher rate of remaining depressed over time, and a lower rate of making the transition to nondepressed status or to death over time.

"Older men generally have higher mortality rates than older women, irrespective of depression. [But] the mortality difference by sex was marked, with a nearly threefold difference in the odds ratios for those who were depressed, compared with those who were not," they said, noting that previous studies may have been unable to detect these patterns because they did not account for fluctuations in depression over time.

"The consistency of our findings over four different time intervals provides strong evidence that depression is more likely to persist in older women than in men. [This] is somewhat surprising because women are more likely than men to receive pharmacologic and nonpharmacologic treatment for depression," the researchers said.

"Whether women are treated less aggressively than men for late-life depression or are less likely to respond to conventional treatment is not known, but should be the focus of future research," they said.

The study was supported by grants from the National Institute on Aging.

The researchers reported no disclosures. ■

Prozac No Better Than Placebo in Teens With Substance Abuse Issues

BY DIANA MAHONEY
New England Bureau

BOSTON— Fluoxetine is not an effective treatment for depression in adolescents with comorbid substance-related disorders, suggest results of a placebo-controlled trial presented at the annual meeting of the American Academy of Child and Adolescent Psychiatry.

Previous studies have suggested that—in adolescents with comorbid major depression and alcohol use disorder in particular—fluoxetine may minimize depressive symptoms and drinking.

The data suggest that there was no difference between the groups in terms of change in depression scores.

DR. FINDLING

In the current study, designed to assess the efficacy and tolerability of fluoxetine in adolescents aged 12-17 years who were diagnosed with depression and a substance use disorder, Dr. Robert L. Findling and his colleagues at University Hospitals Case Medical Center, Cleveland, showed that the effect of treatment with the selective serotonin reuptake inhibitor was comparable with placebo in alleviating depressive symptoms. Additionally, patients treated with fluoxetine did not show a significantly greater decrease in their substance use, compared with patients who received placebo.

The 34 adolescents (mean age 16.46 years) who were enrolled in the trial met DSM-IV-R (revised) criteria for major depressive disorder or dysthymic disorder, and all had depressive symptoms of at least moderate severity, Dr. Findling reported in a poster presentation.

In addition, all the patients had a comorbid substance use disorder, including cannabis use disorder (in 56%), polysubstance use disorder (39%), and alcohol use disorder (11%).

For the study, 18 patients were randomized to receive 10-mg fluoxetine for 4 weeks, after which the dose could be increased to 20 mg, and 16 patients were randomized to placebo with a matching increase after 4 weeks.

The primary study outcome was mean change from baseline to end point in depressive symptoms and psychosocial functioning, based on Children's Depression Rating Scale–Revised (CDRS-R) scores. Additional measures included the Clinical Global Impressions–Severity (CGI-S) scale, the CGI-improvement (CGI-I) scale, the Beck Depression Inventory (BDI), the Beck Hopelessness Scale (BHS), and the Children's Global Assessment of Functioning (CGAS). Rates of positive urine drug screens were calculated.

Comparison of the primary outcome via mixture model analysis demonstrated no treatment difference in mean change in CDRS-R total score, said Dr. Findling, who also noted that no significant treatment-by-visit interaction was observed in the random effects regression model, "suggesting there was no difference between treatment groups [in mean CDRS-R] change over time."

No statistically significant differences in mean change from baseline were observed in any of the measures of depressive symptoms and psychosocial functioning, and an analysis of urine drug-screen results showed no difference in the rates of positive screens between treatment groups, he said.

Treatment was discontinued before 8 weeks by three patients in the placebo arm and six in the fluoxetine arm because of lack of efficacy, Dr. Findling said. Enrollment in the trial was stopped after the 8-week analysis based on the prespecified futility stopping rule.

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