Review Article

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Postpartum Emotional Disorder – Rare but Severe

Lekshmi Sudhish Nair

Author Affiliation: Assistant Professor, Department of Nursing, Krishna Institute of Nursing Sciences, Krishna Institute of Medical Sciences Universities, Karad, Maharashtra 415539, India.

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Abstract

An important and neglected part of midwifery is considering emotional aspect of mother during antenatal and post natal stages. This article highlights the important psychological variations occurs at postnatal period. Baby blues are characterized by mild depression and mood swings as well as tearfulness, sadness, sleep problems, irritability, anxiety, changes in appetite and eating behaviors, and problems concentrating. Postpartum depression shares many same symptoms as the baby blues but the symptoms last longer and are more severe. Postpartum psychosis is an extremely rare and serious disease characterized by depressive symptoms along with delusions and/or hallucinations. The Edinburgh Postnatal Depression Scale (EPDS) is a validated screening tool for postpartum depression. Assess if the patient has any physical problems that are presenting for depression. Various psychopharmacological and psychotherapies are available for the treatment of these disorders.

Keywords: Postpartum; Depression; Baby blues; Postpartum psychosis

Introduction

Having a baby can be both an exciting and thrilling time for any mother. However, it can also be a time when many new mothers feel overwhelmed. Nearly 10 percent of new mothers experience a distress known as postpartum depression. Baby blues are characterized by mild depression and mood swings as well as tearfulness, sadness, sleep problems, irritability, anxiety, changes in appetite and eating behaviors, and problems concentrating. The onset usually occurs within a few days of giving birth and the baby blues are a transitory state that resolves rapidly, lasting from several days to 2 weeks. Baby blues are estimated to affect up to 85% of women and attributed to the hormonal changes that occur following birth characterized by abrupt decreases in estrogen and progesterone. Assess if the patient

Corresponding Author: **Lekshmi Sudhish Nair**, Assistant Professor, Department of Nursing, Krishna Institute of Nursing Sciences, Krishna Institute of Medical Sciences Universities, Karad, Maharashtra 415539, India.

E-mail: nairlekshmi86@gmail.com

has any physical problems that are presenting for depression- ex: thyroid function. Treatment options for women with postpartum depression range from support groups to pharmacotherapy. Postpartum depression shares many same symptoms as the baby blues but the symptoms last longer and are more severe. It is estimated that 7% to 15% of women experience postpartum depression with 0.1% to 2% experience postpartum psychosis. Most women with postpartum depression affected during the first 4 months following birth but it can occur anytime during first year. Difficult to predict it.

Postpartum psychosis is an extremely rare and serious disease characterized by depressive symptoms along with delusions and/or hallucinations. Its onset is within 1 month of delivery. Prompt evaluation by a psychiatrist is required. Treatment usually includes hospitalization and pharmacotherapy. Women with a history of psychosis, bipolar disorder before pregnancy are at a particularly high risk of this disorder. Delusional beliefs about the baby being defective, dying, is Satan, or may experience auditory hallucination to harm self or infant. Risk of infanticide and suicides high as 4%. Women with postpartum blues do not meet criteria for major depression. This common disease begins within a week of delivery and typically improves within 2 weeks. It is treated with reassurance and emotional support. One in 10 women will suffer from postpartum depression, which closely resembles major depression. Symptoms begin within the first year after delivery and can last a few months to over a year. As with major depression, medication or psychotherapy are appropriate treatments.

History Collection

a. History of prior depressive episodes, family history of depression (or any mental disorders, especially mother's history)
b. History of childhood abuse, neglect
c. Single parent; low SES
d. Absence of emotional, social support
e. Unplanned pregnancy
f. Domestic conflict, violence, abuse
g. Susceptibility to hormonal changes, PMS, PMDD
h. Recent loss, death, stressful life events
i. Any infant health problems (ex: colic, patient whose mother was unable to be present at birth of her baby)

Nurse Should

- Inquire about mood history before delivery
- Alert patient to note mood changes on continuum
- Severity guides treatment

Tools for Screening

Two questions have been found to be useful for the identification of patients with depression.

- During the past month, have you been bothered by little interest or pleasure in doing things?
- During the past months, have you often been feeling down, depressed, or hopeless?

These questions are asked by the clinician and reflect symptoms of anhedonia and mood. Sensitivity and specificity for depression for these 2 questions have been estimated at 97% and 67%, respectively. A negative answer to both questions is indicative of a negative screen for depression. An affirmative answer to either question warrants more a detailed interview or patient completion of one of the validated self-report scales for depression such as the PHQ-9. A 10-item screening tool with Maximum score is 30, possible depression score: ≥ 10 and Includes item to assess risk of suicide. Woman self-reports how she has been feeling during the previous week for a number of affect states

Patients with identified risk factors for postpartum depression should be screened. The Edinburgh Postnatal Depression Scale (EPDS) is a validated screening tool for postpartum depression and it is considered to have a sensitivity of 86% for scores above 12 and a specificity of 78% for postpartum major depression among women with no prior history of postpartum depression. Screening can be conducted at the 4- to 6-week postpartum visit or the 2-months well-child visit. The EPDS includes 10 questions that ask women to indicate their how they have felt in the past 7 days. Each question is scored on a scale from 0 to 3 and the scale can be easily scored by office staff. The PHQ-9 is the nine item depression scale of the Patient Health Questionnaire. The PHQ-9 is a

powerful tool for assisting primary care clinicians in diagnosing depression as well as selecting and monitoring treatment.

Diagnostic Categories Using the PHQ-9 Include

- Score < 10 associated with a diagnosis of mild or minimal depressive symptoms with treatment focusing on supportive counseling and patient education to seek help if symptoms worsen
- Score 10-14 considered moderate depression with treatment recommendations of watchful waiting, supportive counseling, and treatment with antidepressants or psychological counseling if symptoms do not improve after 1 month
- Score 15-19 is considered moderately severe depression and warrants treatment with an antidepressant and/or psychological counseling
- A score ≥ 20 would be diagnosed as severe major depression and treatment would rely on antidepressants with or without psychological counseling

All patients diagnosed or suspected with depression should be assessed for suicidal thoughts and plans. It is reassuring to know that discussing suicidality with patients does not insult them or increase the likelihood of a suicide attempt. Straightforward questions about hurting oneself and ending one's life work better than questions about "suicide" or "killing oneself".

Patients with suicidal thoughts must be asked about specific plans. Although women are far less likely than men to successfully complete a suicide, women are more likely to attempt it. Patients most often do not admit to being suicidal. If the patient is determined to do it, they will not tell their practitioner. This is why contracting for suicide prevention (an older strategy) should not be used. Patients with thoughts or plans to end their lives must be evaluated immediately by a psychiatrist. Someone should stay with the patient at all times until she is placed in the psychiatrist's care. The psychiatrist will assess the imminent danger of suicide and determine the need for emergency admission versus close outpatient follow-up.

In general, the symptoms of postpartum depression are similar to depression that occurs at other times in women's' lives including sleep disorders, depressed affect, tearfulness, emotional lability, impaired concentration, impaired memory, appetite disruptions, and recurrent thoughts of death or suicide. Symptoms particularly associated with postpartum depression include:

- Anxiety about the infant including worry about the baby's health, wellbeing, and safety.
- Some women may experience intrusive thoughts about harming their infant.
- Feelings of guilt or inadequacy regarding their ability to care for the newborn or a sense of detachment from the infant are also reported by many women with postpartum depression.
- Rejection sensitivity and irritability are common symptoms, as well.

Postpartum depression frequently has atypical features. Atypical does not mean unusual- it means it differs from what we consider to be the more traditional melancholy depression with psychomotor retardation, lack of appetite, and insomnia. With atypical depression, the patient will have hypersomnia, overeating, leaden paralysis, and extreme sensitivity and irritability.

Treatment

Treatment options for women with postpartum depression range from support groups to pharmacotherapy. Assess if the patient has any physical problems that are presenting for depression- ex: thyroid function. Assess thyroid stimulating hormone and CBC tests. Postpartum support groups diminish women's feelings of isolation and provide support. Cognitive behavioral and interpersonal psychotherapy are also effective for the treatment of postpartum depression. Psychotherapy combined with antidepressants are usually the most effective combination treatment regimen. A number of studies confirm the safety of SSRIs for women who are breastfeeding with undetectable or extremely low levels of medication in infant serum.

Selective serotonin reuptake inhibitors (SSRIs) are primarily indicated for the treatment of clinical depression as well as anxiety disorders, OCD, eating disorders, and in some cases, post traumatic stress disorder (PTSD). First-generation tricyclics and monamine oxidase inhibitors are not considered

for first-line therapy of MDD. Some of the most frequently prescribed SSRIs are shown on this slide with approved dose ranges and a brief review of advantages and disadvantages associated with each. The initial suggested dose for citalopram is 20 mg in the morning with food with this dose maintained for 4 weeks. If no response, dose can be increased in 10 mg increments every 7 days as tolerated. Escitalopram is a more potent s-enantiomer of citalopram and the starting dose is lower at 10 mg; this can be increased to 20 mg if partial response after 4 weeks. A 20 mg starting dose is indicated for fluoxetine when taken in the morning with food; the 20 mg dose should be maintained for 4-6 weeks before up-titration of dose in 10 mg increments every 7 days. The recommended starting dose for sertraline is 25 mg once daily with food and this should be maintained for 4 weeks before increasing the dose in 10 mg increments at intervals of about 7 days up to a maximum dose of 50 mg. Duloxetine is also a serotonin and nor epinephrine reuptake inhibitor with a recommended initial dose of 40 or 60 mg as a single or divided dose; dose increases are permitted after 7 days up to a maximum of 120 mg/day although doses > 60 mg have not been shown to have greater efficacy. Dose adjustments are recommended for patients administered duloxetine who have impaired renal function (CrCL < 30 ml/min). Importantly, when patients discontinue duloxetine, it is recommended that the dose interval be gradually increased over 6 or more weeks with dose tapering recommended for patients taking > 50 mg/day. Desipramine and nortriptyline are tricyclic antidepressants that inhibit the uptake of nor epinephrine and serotonin, although they are less effective for serotonin inhibition; tricyclics have anti cholinergic, cardiac, and hypotensive effects and they should be administered with caution to patients with cardiac conduction disorders or congestive heart failure.

Tricyclic antidepressants offer clinicians the advantage of assessment of serum concentration levels to determine patient compliance with therapy as well as the most effective dose. The recommended dose for desipramine ranges between 100 and 30 mg and the recommended starting dose is 50 mg in the morning. The dosage can be increased by 25 to 50 mg every 3 to 7 days up to a target dose of 150 mg for 4 weeks. Nortriptyline is another tricyclic agent with a recommended dose range of 25 to 100 mg and a starting dose of 25 mg to be taken in the evening. The dose can be increased in 10 to 25 mg increments every 5 to 7 days. It is recommended that clinicians obtain a serum concentration level after 4 weeks of therapy with the target range 50 to 150 ng/mL. Nortriptyline is less likely to cause orthostatic hypotension but should be used cautiously for patients with cardiac conduction disorders or congestive heart failure. Other tricyclics include amitriptyline and imipramine. In general, tricyclics offer an effective and less expensive treatment option for depression but they do provoke more side effects and they are more lethal than SSRIs in instances of overdose. Consequently, their use has declined in the past 20 years.

Mirtazapine is a serotonin and norepinephrine antagonist with a recommended starting dose of 15 mg at bedtime; the dose can be increased in 15 mg increments as tolerated, although patients should remain on a 30 mg dose for 4 weeks before up-titration. There are few side-effects such as drug interactions or negative effects on sexual function. Bupropion is a norepinephrine and dopamine reuptake inhibitor and is available in a standard dose and a sustained release formulation. The recommended starting dose for standard bupropion is 100 mg twice/day and 150 mg once daily for the sustained release formulation. Dose increases of 100 mg 3 times a day after 7 days is recommended for the standard formulation up to a maximum of 150 mg 3 times per day. The recommended dose increase for bupropion SR is 150 mg twice per day after 7 days; this can be further increased to 200 mg twice daily after 4 weeks if patients do not obtain an acceptable clinical response. Dose reductions are required for either formulation of bupropion for patients with hepatic dysfunction. Venlafaxine is a serotonin and norepinephrine reuptake inhibitor with a recommended starting dose of 75 mg with food per day, although the dose can be halved for older or frail patients and those with anxiety; it is available in extended release formulations. Venlafaxine can increase blood pressure when taken at higher doses and is associated with a risk of drug interactions. Higher rates of sexual dysfunction are reported for venlafaxine and patients do experience withdrawal symptoms. However, venlafaxine offers the advantage of an effective treatment for anxiety disorders, neuropathic pain, and vasomotor symptoms as well as relief of depression.

Psychotherapy is important part of treatment for women who have past history of depression, developmental abuse, marital conflict, lack of support, or comorbid mental health conditions. Cognitive Behavior Therapy (CBT), Interpersonal Therapy (IPT) and Psychodynamic Therapy are all effective and may be cost-effective in improving long term outcomes.

Conclusion

Emotional Health during post partum period is very important as complete child care is depends on health of the mother. During hospitalization and at the time of discharge it is important to identify the emotional variations and treat them in appropriate time to prevent maternal and child complications.

Reference

1. Beck CT. Postpartum depression: it isn't just the blues. Am J Nurs. 2006; 106(5):40-50.
2. Hirst KP, Moutier CY. Postpartum major depression. Am Fam Physician. 2010; 82(8):926-933.
3. Pearlstein T, Howard M, Salisbury A, Zlotnick C. Postpartum depression. Am J Obstet Gynecol. 2009; 200(4):357-364.
4. Beck CT. Postpartum depression: it isn't just the blues. Am J Nurs. 2006;106(5):40-50.
5. Hirst KP, Moutier CY. Postpartum major depression. Am Fam Physician. 2010;82(8):926-933.
6. Pearlstein T, Howard M, Salisbury A, Zlotnick C. Postpartum depression. Am J Obstet Gynecol. 2009;200(4):357-364.
7. The MacArthur Initiative on Depression and Primary Care. Depression Management Tool Kit. 2009. www.depression-primarycare.org
8. Hackley B, Sharma, C, Kedzior A, Sreenivasan S. Managing mental health conditions in primary care settings. J Midwifery Womens Health. 2010;55(1):9-19.
9. Patten SB, Kennedy SH, Lam RW, et al. Canadian Network for Mood and Anxiety Treatments (CANMAT) clinical guidelines for the management of major depressive disorder in adults. I. Classification, burden, and principles of management. J Affect Disord. 2009. 117(Suppl 1):S5-S14.
10. The MacArthur Initiative on Depression and Primary Care. Depression Management Tool Kit. 2009. www.depression-primarycare.org.
11. Arroll B, Khin N, Kerse N. Screening for depression in primary care with two verbally asked questions: cross sectional study. BMJ 2003;327:1144–6.
12. Beck CT. Postpartum depression: it isn't just the blues. Am J Nurs. 2006;106(5):40-50.
13. Hirst KP, Moutier CY. Postpartum major depression. Am Fam Physician. 2010;82(8):926-933.
14. Pearlstein T, Howard M, Salisbury A, Zlotnick C. Postpartum depression. Am J Obstet Gynecol. 2009;200(4):357-364.
15. Lam RW, Kennedy SH, Grigoriadis S, et al. Canadian Network for Mood and Anxiety Treatments (CANMAT) Clinical guidelines for the management of major depressive disorder in adults. III. Pharmacotherapy. J Affect Disorders. 2009;117():S26-S43.
16. Papakostas GI. The efficacy, tolerability, and safety of contemporary antidepressants. J Clin Psychiatry. 2010;71(Suppl E1):e03.
17. The MacArthur Initiative on Depression and Primary Care. Depression Management Tool Kit. 2009. www.depression-primarycare.org.