Postpartum Depression: An Update

Lori E. Ross, PhD

Research Scientist

Women's Mental Health & Addiction Research Section

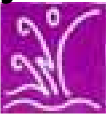
Centre for Addiction and Mental Health

Assistant Professor

Women's Mental Health Program, Department of Psychiatry

University of Toronto

l.ross@utoronto.ca



Postpartum Depression

A guide for front-line health and social service providers

Lori Ross PhD
Cindy-Lee Dennis RN, PhD
Emma Robertson PhD
Donna E. Stewart MD, FRCPC

Toronto Public Health

University Health Network

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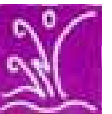

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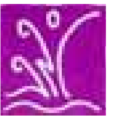

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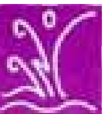
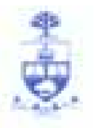

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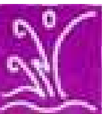
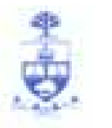
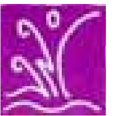




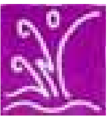
Clinical Overview

- What is postpartum depression?
- How common is it?
- What are its symptoms?
- What other types of mood disorders occur in the postpartum period?



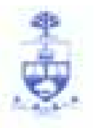
How common is PPD? What are its symptoms?

- **Approximately 13% of women develop PPD** (for comparison: up to 85% develop blues, 0.2% psychosis)
- **Symptoms can include:**
  - Feeling low, sad, empty or tearful
  - Loss of interest/pleasure in activities
  - Changes in weight/appetite/sleep
  - Fatigue/concentration problems
  - Recurrent thoughts of death/suicide
  - Feelings of worthlessness or guilt



What is PPD?

- **Depression that occurs *shortly after birth* (i.e., first year postpartum)**
- **Multi-factorial etiology**
- **PPD does not differ from general depression, other than the context:**
  - Symptoms may focus on baby/birth
  - May be difficult to detect due to normal pregnancy-related changes
  - Impact on baby and family
  - Choice of treatment may be in part determined on factors such as breastfeeding, time commitment



What other mood changes can occur? How are they different?

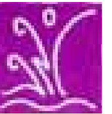
- ***Baby blues:***
  - More common than PPD
  - Earlier onset (first 5 days)
  - Transient (lasts a few hours/days)
  - Less severe than PPD (not treated)
- ***Postpartum psychosis:***
  - Much less common than PPD
  - More severe than PPD (hospitalization is usually required)
  - Psychotic symptoms (e.g., delusions, hallucinations) usually present

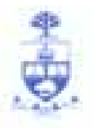
Postpartum Anxiety Disorders

- ***Panic Disorder*** **may be exacerbated or have new onset postpartum**
- ***Obsessive-Compulsive Disorder*** **can also be exacerbated by pregnancy/ childbirth, but OCD symptoms are common in healthy new parents**
- ***Post-traumatic Stress Disorder*** **may be triggered or exacerbated by traumatic birth experiences in vulnerable women**

Prevention of PPD

- What preventive interventions for PPD have researchers and clinicians examined?



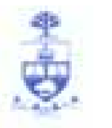


Prevention of PPD

- **What DOESN'T work? (so far)**
  - **Antenatal/postnatal classes**
    - Poor attendance
    - Mothers focused on labour & delivery?
  - **Intrapartum support**
    - Effects on other outcomes (analgesia)
  - **Support groups**
    - Poor attendance
    - Feasibility in rural/remote settings

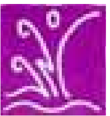
Prevention of PPD

- **What DOESN'T work? (so far)**
  - **Earlier postpartum follow-up**
    - Does follow-up adequately assess PPD?
  - **Psychological debriefing**
    - Structured discussion about a critical life event (e.g., operative delivery)
    - Results suggest this could cause harm
  - **Progesterone therapy**
    - Research suggests this may cause harm



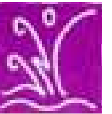
Prevention of PPD

- **Experimental interventions**
  - **Prophylactic antidepressant therapy**
    - Only for women with history of severe PPD
  - **Estrogen therapy**
    - More research is needed to determine risk/benefit profile
  - **Thyroid hormone therapy**
    - Effective only for women with postpartum thyroid dysfunction



Prevention of PPD

- **What MIGHT work?**
  - **Educational interventions**
    - Enable women to seek treatment sooner (secondary prevention)
  - **Psychotherapy**
    - Interpersonal psychotherapy
    - Cognitive behavioural therapy
    - Accessibility is a problem



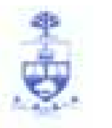
Prevention of PPD

- **What MIGHT work?**
  - **Flexible postpartum care, including:**
    - Home visits
    - Use of symptom checklists (e.g., EPDS) to determine maternal needs
    - Protocols for assessment and referral
    - Tailoring care to specific maternal needs
  - **Interventions to target "mothers at risk" rather than all mothers**
  - **Interventions during the postnatal period (rather than prenatal)**

Prevention of PPD: Summary

- **Results are not really surprising:**
  - *If there is no single cause, there can be no single cure*

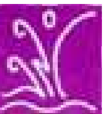
- **Comprehensive, flexible postpartum care may benefit maternal mood and could have other benefits as well**

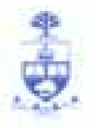


Treatment of PPD

- What treatments are likely to be effective for postpartum depression?

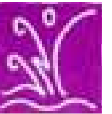
- Are antidepressants safe for use while breastfeeding?





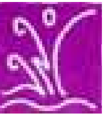
Treatment of PPD

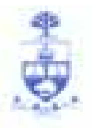
- **What DOESN'T work? (so far)**
  - **Support groups**
    - Poor attendance (many barriers)
    - Feasibility in rural/remote settings
    - Important not to mix groups (depressed and well mothers within the same group)



Treatment of PPD

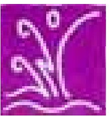
- **Experimental interventions**
  - **Estrogen therapy**
    - More research is needed to determine risk/benefit profile
  - **Bright light therapy**
    - Very limited research evidence to date





Treatment of PPD

- **What works for general depression?**
  - **Antidepressants**
    - For breastfeeding women: risk/benefit analysis will be necessary
  - **Psychotherapy**
    - Interpersonal psychotherapy
    - Cognitive behavioural therapy
    - Psychodynamic psychotherapy
    - Accessibility is a problem
  - **Electroconvulsive therapy (ECT)**
    - For severe/unresponsive depression



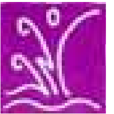
Treatment of PPD

- **What else MIGHT work?**
  - **More support from the partner**
    - Dependent on the quality of the relationship
    - Support from family members may also be effective for women without partners
  - **Non-directive counselling**
    - Supportive listening visits
    - Need North American evidence
  - **Peer telephone support**
    - One small Canadian trial
    - Currently testing a preventive intervention

Antidepressants and Breastfeeding

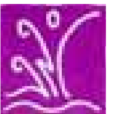
- **For the most commonly prescribed antidepressants (SSRIs):**
  - Levels transmitted through breastmilk are typically <10% of maternal dose
  - Levels in infant plasma are typically low or undetectable
  - Caution should be used if infant is premature or ill
  - Potential long-term effects unknown

- **Need to balance the risks and benefits for each individual case**



Treatment of PPD: Summary

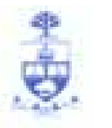
- **As for prevention:**
  - *If there is no single cause, there can be no single cure*
- **If groups are to be offered:**
  - *Barriers for new mother must be addressed (childcare, transportation)*
- **Home visiting interventions may be preferred**
  - *Resource implications*



Assessment & Screening

- Should service providers screen women for PPD?

- What tools do clinicians use to detect PPD? How can they be used?

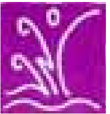


Criteria for a Screening Program

- **Condition must be an important health problem**

- **Accurate and acceptable screening tools must be available**

- **Health care system must have adequate resources available:**
  - *Ensure that individuals who screen positive will receive appropriate and effective care*



Criteria for a Screening Program: PPD

- **Condition must be an important health problem √**
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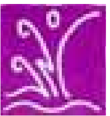
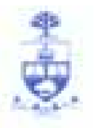


Does Screening Benefit Mothers?

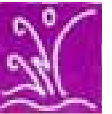
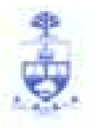
- **Screening improves detection of PPD**
- **So far, screening does not increase the number of mothers who receive appropriate treatment**
- **So far, screening does not increase the number of mothers who recover from PPD**
- **Likely due to inadequate/ineffective treatment resources**



To Screen or Not to Screen?

- **More research is sorely needed**
  - *If you are screening in your centre, incorporate an evaluation of outcomes!*

- **Direct available resources towards developing care pathways and enhancing treatment resources**

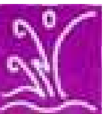
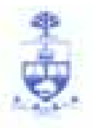
The Edinburgh Postnatal Depression Scale (EPDS)

- Most widely used tool for clinical screening and research on PPD
- 10 items, multiple choice style
- Well-validated for use both in pregnancy and the postpartum
- Has been translated into at least 23 languages for use worldwide
- Easy and acceptable to patients
- Easy to score and interpret

Cox et al. (1987) Br J Psychiatry 150; 782-86

The EPDS: Words of Caution

- **Will miss some cases, especially women with physical symptoms (may want to ask additional questions about appetite, sleep)**
- **Doesn’t pick up on only depression: also anxiety, “normal” adjustment**
- **Doesn’t give a diagnosis: separates women who probably require help from those who probably do not**
- **Clinical information MUST be used in addition to the EPDS score.**

The EPDS: What do the scores mean?

- **<9: probably not depressed**
- **9-12: possible depression. May require follow-up, referral.**
- **>12: probable depression. Requires follow-up, possible referral.**

- **Scores on Item 10 (suicide):**
  - Always check this item apart from the total score
  - Any score >0 requires follow-up

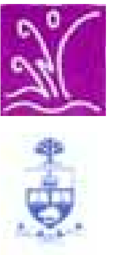
Note: *These scores are validated for Caucasian, English-speaking women.*

Assessment & Screening: Summary

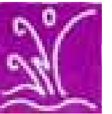
- **The EPDS can be a useful tool for confirming symptoms of depression**
  - *Scores MUST be interpreted together with clinical judgment!*

- **There is not presently sufficient evidence that the potential benefits of PPD screening outweigh potential costs**

- **Development of care pathways is an important first step**



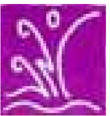
Open Discussion/ Q&A



Diverse Populations

- What populations have unique mental health needs during the postpartum period?

- What strategies can service providers use to ensure that they meet the needs of all women who require PPD-related services?



Culturally Diverse Women

- **Rates of PPD are approximately equivalent across cultures**
- **Elevated rates in Canadian immigrants**
- **Possible culturally-specific risk factors**
- **Protective role of childbirth rituals?**
- **Difficulties in detecting PPD:**
  - *Different symptom presentation?*
  - *Problems with translated screening tools*
  - *Contextual relevance of PPD across cultures?*
  - *Appropriateness/accessibility of services?*

Culturally Diverse Women

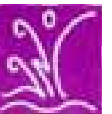
- **Suggested strategies:**
  - Seek out cultural sensitivity training
  - If desired: help women make connections within their communities
  - Work in partnership with community-based agencies to educate and offer services to diverse communities
  - Disseminate information and offer services in as many languages as possible

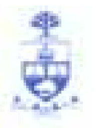
Rural and Remote Women

- **Conflicting evidence about rates of PPD in rural women, unknown in remote**
- **Because of barriers accessing care, R&R women may have more severe PPD by the time they present to a care provider**
- **May be more likely than urban women to have immediately family or friends close by on whom they can rely for help**
- **Myths about motherhood may be more deeply entrenched**
- **Communities may be too small for groups to be feasible**

Rural and Remote Women

- **Suggested strategies:**
  - Offer PPD support through methods other than face to face, e.g., telephone
  - Develop clear client/provider boundaries on the first contact
  - If groups are to be offered: clearly outline confidentiality policies
  - If the community is too small for groups: consider one-to-one support by a trained peer volunteer



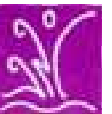


Aboriginal Women

- No research has established prevalence or risk factors for PPD in Canadian Aboriginal women
- Aboriginal communities are diverse, each with unique values and traditions about health and childbirth
- Aboriginal women are at high risk for depression, suicide, and substance use
- Isolation may be a factor: women may leave communities to give birth; may have disrupted kinship bonds due to residential schools, forced adoption

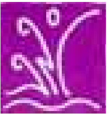
Aboriginal Women

- **Suggested strategies:**
  - If you work with Aboriginal communities: be a leader in partnering with the community to conduct research in this area!
  - Where possible/appropriate, consult with family members and elders in developing treatment plans
  - Strive to be knowledgeable and respectful of Aboriginal beliefs and traditions and reflect them in your care plans



Adolescent and Single Mothers

- **Both adolescent and single mothers show high prevalence rates of PPD**
- **PPD risk factors common in adolescent and single mothers:**
  - Lack of social support
  - Unplanned and/or unwanted pregnancies
  - Low socioeconomic status
- **Adolescent and single mothers likely also face significant barriers to treatment**



Adolescent Mothers

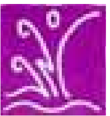
- **Suggested strategies:**
  - Find out what other workers or service providers are involved in her care and coordinate services
  - Enlist support from family members and partner as much as appropriate
  - Treat each contact as if it could be your last: don't wait to offer referrals
  - Accompany her to appointments with providers you refer her to if possible
  - Refer to parenting education, social services as needed

Single Mothers

- **Suggested strategies:**
  - Help her think creatively about who can make up her support network: a favourite aunt? A neighbour?
  - Help her to connect with other mothers who may have little support
  - Cover the costs of childcare and transportation whenever possible
  - Over referrals to education, housing, employment, and other social services as needed

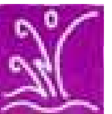
Lesbian and Bisexual Mothers

- **Many women in same-sex relationships are choosing to parent through donor insemination or adoption**
- **Some unique risk factors for PPD:**
  - *Lack of support from families of origin*
  - *Homophobia/heterosexism due to social disapproval of gay and lesbian parents*
  - *Discrimination at the hands of health and social service providers*
- **Some variables may be protective:**
  - *Planned pregnancies*
  - *Equal division of child-care labour*



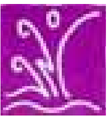
Lesbian and Bisexual Mothers

- **Suggested strategies:**
  - Don’t make assumptions about her sexual orientation: use gender-neutral language to inquire about partners
  - Check your own biases and assumptions about lesbian mothers
  - Find out who is in her support network and include whoever she defines as her family members
  - Connect her with other lesbian and gay parents through online resources



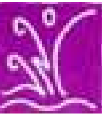
Adoptive Mothers

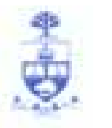
- **Limited available evidence suggests some adoptive mothers face depression shortly after adoption, though it is probably less common than PPD**
- **Adoptive mothers attribute depression to many of the same factors as birth mothers (e.g., sleep disruption)**
- **Unique issues for adoptive mothers:**
  - *Idealization of motherhood, high expectations*
  - *Unresolved infertility issues*
  - *Stress & intrusiveness of adoption process*
  - *Concerns about disrupted attachment*



Adoptive Mothers

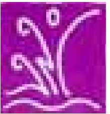
- **Suggested strategies:**
  - Connect mothers with individuals or services that can address the specific causes of their distress: e.g., mobilize partner to help with night needs; referral to counseling re. infertility
  - Educated mothers & families about the myths of motherhood
  - If desired, help her make connections with other adoptive mothers





Women with Disabilities

- **Many women are parenting in the context of disabilities (physical, learning, et al.)**
- **Some unique risk factors for PPD:**
  - *Stigma: assumption that women with disabilities are unfit or unable to mother*
  - *Difficulties balancing their own needs against their of a new baby (e.g., need for sleep, rest)*
  - *Perception that any difficulties are related to the disability, rather than normal challenges*
- **Many women with disabilities develop substitute skills which enable them to manage their children's needs**



Women with Disabilities

- **Suggested strategies:**
  - Reassure mothers about the normal range of child behaviour problems and parenting stress
  - Work with each mother individually to determine her skills and needs
  - Help her to connect with the specific resources/services she needs
  - Ensure care co-ordination so the mother is not overwhelmed by multi-agency involvement

Diverse Populations: Summary

- **Each experience with pregnancy and infant care is different**
  - *Don't make assumptions about what issues will be important to an individual mother*
- **Consider the social context for each individual women you care for**
  - *Refer to social services whenever appropriate*
- **Involve communities in service development and implementation**
  - *Women are the best "experts"*