POSTPARTUM DEPRESSION

Detection and Treatment in the Primary Care Setting

Christina Munoz, Janyce Agruss, Amy Haeger, and Lynn Sivertsen

Postpartum depression (PPD) is a significant mental health problem that affects women and their families worldwide. PPD is a medical diagnosis with specific diagnostic criteria. This article is intended to help the advanced practice nurse (APN) who works with postpartum patients identify women at risk, understand how to correctly diagnose PPD, and obtain appropriate and lifesaving treatment for the women in need.

ABSTRACT

Postpartum depression (PPD) is an illness that is often overlooked. Its consequences suggest that nurse practitioners should be more proactive in looking for this problem. This article provides the advanced practice nurse with the necessary tools to assess risk, screen, recognize symptoms, and diagnose PPD based on current literature. Treatments are highlighted, and resources for the practitioner are provided. A case study is presented to illustrate current treatment guidelines in a primary care setting.

Keywords: baby blues, depression, postpartum, postpartum blues, postpartum depression

PREVALENCE

The prevalence of PPD varies depending on the study method used and timing of evaluation. A meta-analysis of community

Table 1. Comparison of Postpartum Affective Disorders

Disorder	Onset and Duration	Symptoms	Treatment
Postpartum Blues	Onset is 3-4 d postpartum and can last 12 h to 2 wk	Rapid but mild mood swings, irritability, tearfulness, anxiety, and insomnia	No treatment required, except support and reassurance
Postpartum Depression	Onset is within 6-12 mo postpartum and can last weeks to months	More extreme disturbances in appetite, sleep, and libido; intense anxiety, fatigue, and/or feelings of guilt	Counseling, therapy, medication, or combination usually required by health care professional
Postpartum Psychosis	Onset is up to 2 wk postpartum and can last weeks to months	Symptoms are severe and include disorganized behavior, rapid mood swings, delusions, and hallucinations	Hospitalization usually required

studies found the prevalence of PPD to be 13%.[1] Globally, published PPD prevalence rates range from 2.1% in Zurich, Switzerland, to 31.6% in Bordeaux, France.[2]

DEFINITION

Postpartum affective disorders can be divided into three main categories: postpartum blues, PPD, and postpartum psychosis. Postpartum blues is the most common, with a prevalence of 40% to 80%. Postpartum psychosis is rare, with a prevalence rate of 0.1% to 0.2%.[3,4] A comparison of the three disorders is shown in Table 1.[3-6]

RISK FACTORS

Research has shown that many cases of PPD begin during pregnancy; therefore, being aware of the risks is essential to tailoring patient-specific interventions.[7] In a retrospective study of women with PPD, 50% reported that symptoms began before or during their pregnancy.[8] Despite this, a systematic review of 16 studies has shown poor predictive value and sensitivity about screening tools used antenatally. No screening instruments met the criteria for antenatal screening; therefore, only postnatal use of screening tools is recommended.[9] Conversely, assessment of patients' past psychosocial and medical history antenatally is helpful in identifying mothers at greater risk and is still warranted.

A synthesis of three meta-analyses about risk factors for PPD concluded the strongest risk factors for postpartum depression are as follows: depression during pregnancy, anxiety during pregnancy, life events such as losing a job or divorce, and past history of psychiatric illness.[10] Inadequate social support, childcare-related stressors, and poor quality relationship with a partner have been consistent predictors of PPD, whereas low socioeconomic status and difficult infant temperament have not been upheld as consistent predictors of PPD.[11,12] Cultural groups in India, China, and Nigeria have consistently found that female babies are looked down on, and this gender bias may increase the risk of PPD in mothers with female babies.[2,13,14]

CAUSE

The cause of PPD is unknown, but research suggests the cause is multifactorial. The National Mental Health Association (NMHA) describes the cause of PPD as a composite of three interrelated factors: hormone fluctuations, situational risk, and life stresses.[11] On the basis of the information from the NMHA, we have developed the triad of pathogenesis shown in Figure 1. The hormone fluctuations noted in the triad involve decreased serotonin and estrogen levels after delivery. Examples of situational risks include a death in the family, divorce, or loss of a job. Life stresses that may also lead to the development of PPD include balancing career and motherhood, loss of former roles or freedoms, relationship stresses, and unresolved feelings about the pregnancy.[11,15]

CLINICAL MANIFESTATIONS

In general, the clinical manifestations of PPD include severe changes in sleeping, eating, and activity patterns. For example, a woman may not be able to sleep even when her baby is sleeping, or she may sleep excessively. A woman with PPD may tell you she forces herself to