Concise Review for Physicians and Other Clinicians: Postpartum Depression

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CME Activity

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Abstract

Postpartum depression (PPD) is a common, potentially disabling, and, in some cases, life-threatening condition. Fortunately, PPD is also readily detectable in routine practice and is amenable to treatment by a wide variety of modalities that are effective for treating nonpuerperal major depression. Postpartum depression screening can improve case identification (an Edinburgh Postnatal Depression Scale score of $\geq$13 indicates a high risk of PPD) and, when associated with a diagnostic and follow-up program, leads to improved clinical outcomes. Symptom severity, patient preference, past response to treatment, availability of local mental health care resources, and patient decisions about breast-feeding will drive management decisions. In general, cognitive-behavioral therapy and interpersonal therapy are preferred psychotherapies for women with mild to moderate PPD, whereas antidepressants are appropriate in more severe cases. Many patients will require other types of assistance, such as parenting support, case management, or care coordination because many barriers to receiving adequate PPD treatment must still be overcome.

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Postpartum depression (PPD), the onset of depressive episodes after childbirth, is the most common postnatal neuropsychiatric complication. Postpartum depression affects 10% to 20% of women after delivery, regardless of maternal age, race, parity, socioeconomic status, or level of education.[1] Postpartum depression can lead to impaired maternal functioning and child development.[2,3] Yet, fewer than half of PPD cases are diagnosed in clinical practice, thus prompting vigorous efforts at improving case detection and implementing evidence-based treatment.[3] This article provides a clinical update on the etiology, risk factors, diagnosis, and treatment of PPD.

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CLINICAL FEATURES

Diagnostic Criteria

There is no specific diagnostic classification for PPD. However, signs and symptoms of PPD are identical to those of nonpuerperal major depression,[3] and major depressive episodes are diagnosed by using the usual criteria, but with a pregnancy or postpartum onset specifier. Previously adopted diagnostic criteria for PPD (major depressive disorder, with postpartum onset) required an onset of major depressive episodes within 4 weeks after childbirth (Table 1). The "postpartum onset" specifier has been criticized because a large number of diagnosed PPD episodes actually begin during pregnancy.[4] Thus, recently updated diagnostic criteria in *Diagnostic and Statistical Manual for Mental Disorders, 5th edition* (*DSM-5*) now classify major depressive episodes "with peripartum onset," encompassing cases with symptom onset during pregnancy or in the 4 weeks after delivery.[4]

Currently, depressive episodes occurring after the end of the fourth postpartum week would not meet *DSM-5* diagnostic criteria for "peripartum onset." The 4-week time frame after delivery for defining PPD, however, may be overly conservative. Indeed, longer time frames (up to 12 months postpartum) have been used in research studies to define PPD.[2] Furthermore, the onset of depressive episodes remains high for several months after delivery in postpartum women (see below). And finally, in practical terms, women are usually available for depression screening between 4 and 12 weeks during routine postpartum follow-up, and it seems unlikely that the optimal time for PPD screening and evaluation would end at 4 weeks postpartum.

Onset and Course

The prevalence of PPD appears to peak at 2 to 6 months after delivery, and as many as 14.5% of postpartum women may experience a new depressive episode within 3 months after delivery.[1] Most patients experience mild depressive symptoms; however, 10% to 15% will have more severe symptoms that clearly worsen maternal functioning. Postpartum depression persists for more than 7 months after delivery for 25% to 50% of women, and many remain depressed after 1 year.[5]

Consequences

Postpartum depression is associated with impaired mother-infant bonding, negative parenting practices, unsuccessful breast-feeding, and marital discord, as well as worse cognitive and social development in offspring.[2,3] However, remission of maternal depression reduces the risk of behavioral problems and psychiatric symptoms in offspring.[2,6] A previous episode of PPD increases the risk of future episodes of PPD, a future diagnosis of bipolar disorder, and nonpuerperal major depressive episodes.[7] Postpartum depression is a risk factor for maternal suicide, which accounts for up to 20% of postpartum deaths.[8]

DIFFERENTIAL DIAGNOSIS AND COMORBIDITY

Differential Diagnosis

Disturbed sleep and appetite are normal postpartum occurrences; however, the onset of clinically significant depression and anxiety should prompt clinicians to consider a diagnosis of PPD. Coexisting medical conditions that can mimic or exacerbate PPD include postpartum thyroid disorders and anemia. Deficiencies in selected micronutrients (eg, B vitamins and vitamin D) have been linked with nonpuerperal major depression, but a firm association with PPD has not been established.

Signs and symptoms of several psychiatric conditions overlap with PPD, and must be ruled out. These include the following:

- Postpartum blues occurs in 50% to 80% of new mothers. Signs and symptoms appear within 1 to 2 days postpartum and include depressed mood, anxiety, tearfulness, irritability, poor appetite, and sleep problems. These changes are mild and resolve spontaneously within 10 to 14 days[5]; however, up to 25% of the patients with postpartum blues develop PPD.[9]
- Postpartum psychosis is a rare (<2 cases per 1000 postpartum women) but serious condition characterized by delusions, hallucinations, severe and rapid mood swings, sleep disturbances, and obsessive preoccupation about the baby. These signs and symptoms emerge within 1 to 4 weeks after delivery and require urgent evaluation and hospitalization given a high risk of suicide

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