Postpartum Depression

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Objectives

• Define postpartum depression

• Discuss how to assess and evaluate symptoms of postpartum depression

• Identify two approaches that can be utilized when working women with postpartum depressive spectrum symptoms.

• The views presented in the presentations are the views of the presenters and not the views of the US Army or the US Military.

• We have no financial disclosures.

• No off label medication utilizations will be made in this presentation.
What Is PPD?

• PPD has become a general term used within US society to denote any psychiatric illness that occurs after childbirth.

Photo from Campaign for a Commercial Free Childhood: commercialfreechildhood.blogspot.com

PPD Really Is ......

One of the four syndromes that can occur after childbirth.

FOUR SYNDROMES:
1.) Postpartum Blues
2.) Adjustment D/O after postpartum period
3.) Major Depression
4.) Postpartum Psychosis
Criteria/Definition of Postpartum Depression

• The DSM-IV does not recognize postpartum depression as a separate diagnosis; rather, patients with a diagnosis of postpartum depression must meet the criteria for both major depressive episode and the criteria for the postpartum onset specifier.

• A range of mental health problems including depression, anxiety or panic disorder, OCD, PTSD, psychosis and bipolar (PSI, 2011).

Epidemiology

• 85% experience some kind of mood disturbance in postpartum period
• 5-25% of perinatal women experience postpartum depression.
• 40-60% of low income women and pregnant and parenting teens experience postpartum depression.
• 0.1% experience postpartum psychosis.
• 10% of fathers & 14% of mothers experience depression symptoms (CESD) (Paulson, Dauber, Leiferman, 2006).

Current Theories

• Hormonal Imbalance
• Role Collapse (Amankwaa, 2005)
• Lack of social support
• Bronfenbrenner’s Ecology Theory
• Social Energy Exchange Theory for Postpartum Depression (Posmontier & Waite, 2011)
• Medical model
• Feminist theory
• Attachment theory
• Interpersonal theory
• Self-labeling theory.
Factors related to Perinatal Mental Health

- **Strong risk factors**
  - Depression and/or anxiety during pregnancy
  - Past psychiatric illness
  - Life events
  - Social support

- **Moderate risk factors**
  - Psychological distress
  - Marital/relational problems

- **Small**
  - Socioeconomic status including income, employment, education
  - OB experiences—complications of pregnancy and delivery (Stewart et al. 2003)

Prevention or Protective Factors

- Adequate social support
- Adequate financial resources
- Adequate healthy lifestyle
- Early psychotherapy intervention (Zolotnik et al. 2001)
- Early pharmacological intervention (Wisner et al. 2004)

Screening and Recognition

- “You can’t tell by looking” (PSI 2009)
- Routine screening reduces stigma
- Edinburgh Postnatal Depression Scale (can be used during pregnancy also)
  - Ten Items—0-30; cut-off 10-13 (question 10—suicide)
- PHQ9
  - Nine Items—0-27; 5-9 Mild depression; 10-14 Moderate depression; 15-19 moderate/severe depression; 20-27 severe (i question—suicide)
- At each pregnancy visit, 1, 4 and 6 months well-child (AAP)
Clinical Interview

- Biopsychosocial
  - Include trauma history
  - Pregnancy/delivery history (current and past)—birth story
  - Family history and current living situation
  - Intrusive thoughts
  - Sleep, nutrition, exercise
  - Losses changes during past year
- Social support, financial resources, lifestyle

Treatment/Interventions

- Psychoeducation
- Support Groups
- Psychotherapy
- Psychopharmacology
- Home visit

Psychotherapy

- Group and Individual have been shown to be effective.
- Some studies have cited that individual therapy preferable to group therapy for PPD.
- Orientations: Interpersonal, CBT, Supportive, and Psychodynamic
- Limited access to providers with interest or expertise in PPD
Psychopharmology

Pregnancy
• FDA Pregnancy Class—A-D
• SSRI—prozac & celexa—C
• Buspar—B
• Wellbutrin—C
• Mood stabilizers
• Antipsychotics—EPS/movement in newborns

Postpartum—LactMed
• All antidepressants show up in breast milk and have levels in infant
• Uses those that are lowest levels in infant with lowest dose to manage symptoms

Short-Term Group Psychotherapy

• For first-time mothers, risk of PPD may be greater when compared to women with previous childbearing experience, because there is nothing from which to compare their postpartum experience (Epperson, 1999).
• High expectations and lack of experience around the postpartum experience can lead first-time mothers to attempt to normalize the PPD experience, to lack awareness, or to ignore onset of serious depressive symptoms (Sword, 2002).

Short-Term Group Psychotherapy Intervention

• Hospital-based program
• New role for the APN
• Focused on 1st moms
• Non-pharmacological intervention
• Women at risk for PPD
• EPDS score 11 or higher
• Use EPDS before and after intervention

Weighing the impact of the mother’s mental illness and the baby’s well-being
Effectiveness of Group Psychotherapy

• Literature articulated effectiveness group psychotherapy for PPD (Klier et al. 2007; Honey, Bennet & Morgan, 2002; Gruen, 1993).
• Literature cited scores of EPDS would decrease and scores did decrease within offered groups.
• Long term effects noted in literature 6 months post intervention; group members also noted similar findings.

Short Group Psychotherapy Intervention

• Eight week therapy groups met weekly for 90 minutes, included 8 women
• Interpersonal orientation
• Daycare provided
• No charge
• Psychiatric APN group leader

Implications for Psychiatric APNs

• Opportunity to increase awareness about non-pharmacologic & pharmacologic interventions
• Articulates importance of continued psychotherapy training for Psychiatric APNs
• Allow Psychiatric APNs to collaborate and integrate into non-psychiatric settings
• Potentially strengthens marketable of the Psychiatric APNs
Working with Military Families

- High risk factors
  - Young families
  - Previous history of mental health concerns
  - History of trauma
  - Separation from family, husband may be deployed
  - Low income
- Collaboration with OB/L&D, Peds and DBH

Perinatal Mood Disorder Program

- Initiated by a committed pediatrician, concerned ob staff and responsive behavioral health leadership
- Elements
  - Consistent screening—Edinburgh Postnatal Depression Scale
    - Mothers screened during pregnancy
    -Primed screening in postnatal period
    - Peds screen 1, 3, 4, 6-month well-baby visits
    - As indicated by assessment
  - Seamless referral
    - Highly trained psych techs available by pager (weekdays/business hours)
    - Peds make weekday on OB/L&D
    - Crisis/urgent response as needed
    - Staff referral by licensed provider
  - Access to Care and Support Services
    - Immediate if necessary
    - Experienced LSCW
    - APRN
    - Experienced providers delivering evidence-based care

Working with Military Families: Treatment Approaches

- Establish rapport
- Cognitive Behavioral Therapy
- Mindfulness Meditation/Relaxation
- Nutrition, Exercise and Sleep
- Trauma treatment
- Normal development and parenting
- Attachment/Bonding
- Husband/father involvement & support
- Outcome measures—PHQ-9 & Edinburgh
- Individual—Couple—Family—Group
Links

- MGH Center for Women’s Mental Health
  www.womensmentalhealth.org
- MedEd Postpartum Depression
  www.mededppd.org
- The Marce Society for Perinatal Mental Health
  www.marcesociety.com
- Postpartum Support International
  www.postpartum.net

References

- Depression in Parents, Parenting, and Children: Opportunities to Improve Identification, Treatment, and Prevention
  http://www.nap.edu/catalog/12565.html