Postpartum unipolar major depression: General principles of treatment

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INTRODUCTION

Although the delivery of a baby is typically a happy event, some postpartum women become depressed. Patients may manifest postpartum blues consisting of mild depressive symptoms that are generally self-limited, or more severe syndromes such as unipolar major depression. Untreated postpartum major depression can result in both short- and long-term negative consequences for the mother and infant [1-4].

This topic reviews the general principles of treating postpartum unipolar major depression. Other topics discuss choosing a specific treatment for postpartum unipolar major depression, the clinical features and diagnosis of postpartum major depression, and the safety of infant exposure to psychotropic drugs through lactation.

- (See "Mild to moderate postpartum unipolar major depression: Treatment".)
- (See "Severe postpartum unipolar major depression: Choosing treatment".)
- (See "Postpartum unipolar major depression: Epidemiology, clinical features, assessment, and diagnosis".)
- (See "Safety of infant exposure to antidepressants and benzodiazepines through breastfeeding".)
- (See "Breastfeeding infants: Safety of exposure to antipsychotics, lithium, stimulants, and medications for substance use disorders".)

GENERAL PRINCIPLES

Patients with postnatal depression are usually best served by a multidisciplinary team that includes an obstetrician or internist and a psychiatrist. Communication among all of the involved clinicians is important to give consistent messages to increase uptake of treatment.

The sections below describe some general principles and issues that are involved in treating postpartum unipolar major depression. Information about the principles of treating unipolar depression in the general population of adults is discussed separately. (See "Unipolar depression in adults and initial treatment: General principles and prognosis", section on 'General principles'.)

Setting — Most women who are considering treatment for perinatal depression prefer to receive help at their obstetrics clinic, either from the obstetrician or a mental health clinician located at the clinic [5]. Randomized trials indicate that depressed patients, including women with perinatal depressive symptoms, can benefit from collaborative (integrated) care that is administered at an obstetrics and gynecology clinic [6,7]. Collaborative care involves a team of clinicians, such as an obstetrician, case manager, and mental health specialist, who work together to provide pharmacotherapy and/or psychotherapy.

Severely ill patients typically require hospitalization. Jointly admitting the mother and infant to a mother-baby unit can facilitate breastfeeding and teaching parenting skills to mothers [8]. These units also allow the treatment team to observe mother-infant interactions and to work with the mother on improving her relationship with her child. These units are ideal; however, more are available in Australia and Europe than the United States.

History of prior treatment — It is important to assess the benefit of previous therapies in order to guide treatment selection for postpartum unipolar major depression. Patients who were successfully treated with a particular psychotherapy and/or antidepressant prior to or during pregnancy should generally receive the same therapy or drug for postpartum depression.

Additional information about assessing patients for postpartum depression is discussed separately. (See "Postpartum unipolar major depression: Epidemiology, clinical features, assessment, and diagnosis", section on 'Initial evaluation'.)

Educating patients and families — For postnatal unipolar major depression, we recommend psychoeducation for the patient and family. Although evidence for the efficacy of psychoeducation is limited [9-11], educating patients about depression is consistent with

multiple treatment guidelines [12-14]. Psychoeducation includes information about the symptoms and course of depression as well as treatment options. The discussion about treating postpartum depression should include information about the potential risks of untreated depression for the mother, mother-infant bonding, infant attachment, child development, and family. (See "Severe postpartum unipolar major depression: Choosing treatment", section on 'Initial treatment'.)

In addition, patients are encouraged to get adequate rest, maintain a consistent sleep-wake cycle, utilize supports such as doulas or night nurses, reduce stressors when possible, and continue prepregnancy exercise routines. (See "Exercise during pregnancy and the postpartum period", section on 'Postpartum individuals'.)

Adherence — Poor adherence is common among patients with psychiatric disorders, including postpartum depression. Barriers to care include cost, logistics, not trusting clinicians, and stigma [15].

Monitoring symptoms — We routinely monitor patients treated for postnatal depression, using the self-report, 10-item Edinburgh Postnatal Depression Scale (figure 1A-B) [16]. The scale can be completed in less than five minutes in the waiting room immediately before seeing the clinician. Although the instrument was originally developed as a screening tool, we find it is also useful for monitoring response to treatment [17]. Items asking about the somatic symptoms of depression such as sleep and appetite are not included in the scale because these symptoms are common in postpartum women who are not depressed [18]. The scale is acceptable to most women and clinicians [19], easy to score, and is available in over 50 languages [20]. Responses are scored 0, 1, 2, or 3, with a maximum score of 30. In studies that evaluated the instrument as a screening tool, scores ≥12 or 13 identified most women with major depression. However, many studies used a cutoff score of ≥10 [21].

A reasonable alternative to the Edinburgh Postnatal Depression Scale is the self-report, nine-item Patient Health Questionnaire (table 1). However, the Patient Health Questionnaire includes items about appetite, energy, and sleep, which may reflect the physical effects of the puerperium rather than depression [22].

General information about monitoring patients during treatment of depression is discussed separately. (See "Using scales to monitor symptoms and treat depression (measurement based care)".)

In addition, nursing infants of mothers who are taking antidepressant medications should be monitored by the pediatrician. (See "Safety of infant exposure to antidepressants and benzodiazepines through breastfeeding", section on 'Monitoring'.)

Prescribing antidepressants — Patients with postpartum major depression who want to breastfeed their babies need to weigh various risks when deciding whether to use antidepressant medications. If the demands of breastfeeding are overwhelming the mother and interfering with recovery from childbirth, maternal well-being should be prioritized over breastfeeding.

In addition, the potential risks of untreated depression need to be weighed against infant exposure to antidepressant medications. There is a general consensus that the benefits of antidepressants outweigh the potential risks to the infant, which are regarded as low. As an example, most SSRIs pass into breast milk at a dose less than 10 percent of the maternal level and are generally considered compatible with breastfeeding of healthy, full-term infants [23]. (See "Severe postpartum unipolar major depression: Choosing treatment", section on 'Initial treatment' and "Safety of infant exposure to antidepressants and benzodiazepines through breastfeeding", section on 'Selective serotonin reuptake inhibitors'.)

For postpartum patients who were treated with antidepressants during pregnancy up until delivery and are maintained on their medication, we continue to prescribe the same dose that was prescribed before delivery [24]. Patients are monitored for adverse effects that may occur because of postpartum pharmacokinetic changes (eg, altered serum medication concentrations) that stem from decreased plasma volume and decreased hepatic enzyme activity.

For patients who initiate pharmacotherapy after delivery, drug doses are similar to those used in the general population of patients with depression. For patients who were successfully treated with antidepressants before pregnancy, stopped treatment during pregnancy, and then resume the antidepressant after delivery, the target dose during the postpartum period is the same dose that kept the patient well prior to pregnancy.

Patients who start or resume antidepressants after delivery and are concerned about adverse effects can be started on lower doses (eg, sertraline 25 mg/day rather than 50 mg/day). Many patients will require the dose to be titrated up; one randomized trial found that among patients who remitted with sertraline, the dose generally ranged between 100 and 200 mg/day [17]. Monotherapy at higher doses is preferred over medication combinations at lower doses [25]. Additional information about antidepressant doses is discussed separately. (See "Unipolar major depression in adults: Choosing initial treatment", section on 'Dose'.)

Managing nonresponse — If patients with postnatal unipolar major depression do not respond to initial treatment, we suggest the following steps:

- Verify that the patient has unipolar major depression rather than a different condition such as bipolar major depression. (See "Postpartum unipolar major depression: Epidemiology, clinical features, assessment, and diagnosis", section on 'Differential diagnosis' and "Unipolar depression in adults: Assessment and diagnosis", section on 'Differential diagnosis'.)

- Ask about adherence with treatment because nonadherence is common during treatment of psychiatric disorders; improving adherence with pharmacotherapy or psychotherapy homework can convert nonresponders to responders.

- Determine whether there are significant life stressors (eg, nonsupportive partner) that need to be addressed.

- Establish if comorbid psychopathology (eg, anxiety disorder, personality disorder, or substance use disorder) is present. If a disorder other than major depression is more salient, treatment should refocus upon the primary problem. Comorbidity in patients with unipolar major depression is discussed separately. (See "Unipolar depression in adults: Clinical features", section on 'Psychiatric'.)

Referrals — Primary care clinicians and obstetricians often manage postnatal unipolar major depression. However, the diagnosis may not be clear or these clinicians may not be comfortable managing postpartum depression and thus refer patients to psychiatrists; referrals are also made if requested by patients. In addition, referral is usually indicated for patients with:

- Severe depression (see "Severe postpartum unipolar major depression: Choosing treatment", section on 'Severity of illness')

- Bipolar major depression (see "Bipolar disorder in adults: Assessment and diagnosis", section on 'Unipolar major depression')

- Suicidal ideation or behavior (see "Suicidal ideation and behavior in adults")

- Aggressive behavior (see "Assessment and emergency management of the acutely agitated or violent adult")

- Psychotic features (eg, delusions or hallucinations) (see "Unipolar major depression with psychotic features: Epidemiology, clinical features, assessment, and diagnosis")

- Catatonia (see "Catatonia in adults: Epidemiology, clinical features, assessment, and diagnosis")

- Poor judgement that places the patient or others (including the infant and other children) at imminent risk of harm
- Psychiatric comorbidity, such as anxiety disorders, eating disorders, or substance use disorders
- Nonresponse to initial treatment

In addition, primary care clinicians and obstetricians may refer patients who are currently euthymic but have a prior history of major depression or other psychiatric disorders for a consultation with an expert in perinatal psychiatry. Referral to social work may also be appropriate; indications include problematic social circumstances, such as intimate partner violence, poverty, unemployment, or homelessness. Social workers can facilitate treatment uptake and coordination of care.

One review found that among all new mothers, at least 2 percent were referred for psychiatric treatment [26].

CHOOSING SPECIFIC TREATMENTS

Choosing specific treatments for postnatal unipolar major depression is discussed separately. (See "Mild to moderate postpartum unipolar major depression: Treatment" and "Severe postpartum unipolar major depression: Choosing treatment".)

SOCIETY GUIDELINE LINKS

Links to society and government-sponsored guidelines from selected countries and regions around the world are provided separately. (See "Society guideline links: Depressive disorders".)

INFORMATION FOR PATIENTS

UpToDate offers two types of patient education materials, “The Basics” and “Beyond the Basics.” The Basics patient education pieces are written in plain language, at the 5th to 6th grade reading level, and they answer the four or five key questions a patient might have about a given condition. These articles are best for patients who want a general overview and who prefer short, easy-to-read materials. Beyond the Basics patient education pieces are longer, more sophisticated, and more detailed. These articles are written at the 10th to 12th grade reading

level and are best for patients who want in-depth information and are comfortable with some medical jargon.

Here are the patient education articles that are relevant to this topic. We encourage you to print or e-mail these topics to your patients. (You can also locate patient education articles on a variety of subjects by searching on “patient info” and the keyword(s) of interest.)

- Basics topics (see "Patient education: Depression in adults (The Basics)" and "Patient education: Coping with high drug prices (The Basics)")
- Beyond the Basics topics (see "Patient education: Depression in adults (Beyond the Basics)" and "Patient education: Coping with high prescription drug prices in the United States (Beyond the Basics)")

SUMMARY

- **Setting** – Most women who are considering treatment for perinatal depression prefer to receive help at their obstetrics clinic, either from the obstetrician or a mental health clinician located at the clinic. (See 'Setting' above.)
- **Education** – We educate patients with postnatal unipolar major depression and families about the symptoms of depression, treatment options, and the potential risks of untreated depression. In addition, we encourage patients to get adequate rest, maintain a consistent sleep-wake cycle, utilize supports, reduce stressors when possible, and continue prepregnancy exercise routines. (See 'Educating patients and families' above.)
- We suggest routinely monitoring symptoms of perinatal depression during treatment with the self-report, 10-item Edinburgh Postnatal Depression Scale (figure 1A-B). However, a reasonable alternative is self-report, nine-item Patient Health Questionnaire (table 1). (See 'Monitoring symptoms' above.)
- Patients with postpartum major depression who want to breastfeed their babies need to weigh various risks when deciding whether to use antidepressant medications. If the demands of breastfeeding are overwhelming the mother, maternal well-being should be prioritized over breastfeeding.

  In addition, the potential risks of untreated depression need to be weighed against the risks of infant exposure to antidepressant medications. There is a general consensus that the benefits of antidepressants outweigh the potential risks to infants, which are regarded as low. As an example, most SSRIs pass into breast milk at a dose less than 10 percent of

the maternal level and are generally considered compatible with breastfeeding of healthy, full-term infants.

For patients who were treated with antidepressants during pregnancy up until delivery and are maintained on their medication, we continue to prescribe the same dose that was prescribed before delivery. Patients are monitored for adverse effects that may occur due to pharmacokinetic changes after delivery. For patients who initiate pharmacotherapy after delivery, drug doses are similar to those used in the general population of patients with depression. For patients who were successfully treated with antidepressants before pregnancy, stopped treatment during pregnancy, and then resume the antidepressant after delivery, the target dose during the postpartum period is the same dose that kept the patient well prior to pregnancy. (See 'Prescribing antidepressants' above.)

- If patients with postnatal unipolar major depression do not respond to initial treatment, we suggest verifying the diagnosis (eg, rule out bipolar disorder), asking about adherence, and determining whether there are life stressors and/or comorbid psychiatric disorders that require attention. (See 'Managing nonresponse' above.)

- **Referrals** – Although primary care clinicians and obstetricians can treat postpartum patients who are depressed, many patients are referred to psychiatrists, especially for more complex clinical presentations, such as severe major depression, suicidal ideation and behavior, psychotic features, and nonresponse to initial treatment. (See 'Referrals' above.)

- Selecting a specific treatment depends in part upon the severity of the depressive syndrome. (See "Mild to moderate postpartum unipolar major depression: Treatment" and "Severe postpartum unipolar major depression: Choosing treatment".)

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