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CLINICAL AND THERAPEUTIC MANAGEMENT IN POSTPARTUM DEPRESSION

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Postpartum depression (PPD) is a mental disorder commonly encountered in mothers, but also in their partners in the first months after birth. Early recognition of the signs and symptoms of this disease by the medical staff in the department of obstetrics and gynecology or by the generalist practitioner and an appropriate treatment determines a favorable outcome of the mother and an optimal development for the newborn. We discuss the need for a prenatal screening, in order to detect women at risk of developing this condition and the need to monitor them in the first months after birth.

Keywords: postpartum depression, pharmacological treatment, psychoterapy

Postpartum depression, also called postnatal depression, is a clinical form depression that can affect both women and men in the first months after birth.

Postpartum depression (PPD) is mainly due to sudden and significant hormonal changes that occur immediately after birth. Thus, the levels of female hormones, like estrogen and progesterone, fall sharply in the hours following birth. These reductions can induce the depressive state, just as only small hormonal changes may trigger mental dysphoria and tension before menstruation. Also, thyroid hormone levels can drop sharply after birth, thus developing a thyroid deficiency that can lead to depression. At the initiation of breastfeeding, uninhibited pituitary activity and increased levels of prolactin are also due to the decrease of dopamine in certain brain regions. As we know, decreased dopamine is linked with the onset of depressive symptoms, anxiety, and obsessive thoughts. However, Edwards [1] showed in a study that increased levels of placental corticotropin-releasing hormone (CRH) during the 25th week of pregnancy can be used as a marker of a possible development of PPD.

These hormonal changes can cause postpartum depression, especially when they are associated with other risk factors, such as the existence of previous depressive episodes (including bipolar disorder), family history of depression, mother who does not naturally breast-feed, smoking, poor socioeconomic status, unwanted/unplanned pregnancy, African race, lesbian or bisexual mothers, lack of partner, friends or family support, or excessive stress experienced after birth [2,3,4,5,6]. Some authors contest the etiological importance of hormonal changes, arguing that the incidence of PPD is as high in fathers as in mothers, but with symptoms that are lower in intensity [7].

Symptoms that have variable intensity, like insomnia, irritability, crying outbursts, overwhelming feelings and emotional lability, are common in the first days after birth (affecting more than half of the women). These condition (also called "baby blues") typically reaches a peak on the fourth day and remits in less than two weeks, when hormonal changes are reducing. Symptoms of depression often remain at subclinical intensity, but they should be monitored by medical staff in order to intervene promptly if they get clinical expression.

Clinical features of mild PPD are similar to those of "baby blues", but are present for longer periods of time (over 2 weeks). In the case of severe PPD, symptoms can occur anytime during the first year after birth, and are identical to those of a severe depression: sadness, loss of interest, difficulty concentrating, psychomotor agitation or slowness, excessive tiredness, appetite disorders (anorexia or bulimia), sleep disturbances (insomnia), decreased libido, thoughts of suicide, ambivalent or negative feelings towards the baby, feelings of guilt about the inability to take care of the child and excessive anxiety about the state of health. Edinburgh postnatal Depression Scale - EPDS is used for early detection of PPD (a score above 13 from 30, on the 10 items of the scale, indicates PPD) [8].

Approximately 1 in 8 women [9] develop long-term postpartum depression in the weeks and months after birth. Hormonal changes and pain caused by spontaneous abortion or birth of a dead fetus may also trigger PPD in many women. Postpartum depression makes it difficult to fulfill the parental duties, affecting child care and the forming of the mother's attachment. Babies of depressed mothers tend to be less attached to their mothers and are slower in acquiring language, age-specific behaviors, and mental development. Without treatment, postpartum depression can last for about seven months, and may continue over one year.

Immediate treatment is important for both mother and child. The sooner treatment is started, the faster the recovery, reducing the chances of depression recurrence and child development is less affected by mother's condition. Antidepressant medication and cognitive - behavioral therapy proved equally effective for many women. Counseling and supportive therapy are considered first-line treatment for mild and moderate postpartum depression. Some studies indicate that postpartum depression symptoms improve after the first meeting, and show significant improvement after the first six sessions [10]. A cognitive-behavioral therapist may advise the patient to control anxiety symptoms through relaxation

techniques or deep breathing exercises. Women with mild depression benefit more from counseling than those with moderate or severe depression, in which combined treatment with antidepressants is mandatory.

Breastfeeding provides many emotional and physical benefits for both mother and child. For this reason, there have been identified antidepressants that are safe during lactation. Thus, it is not necessary to stop breastfeeding during postpartum depression treatment with antidepressants.

Whether or not the woman is breastfeeding, the practitioner will probably recommend a selective serotonin reuptake inhibitor; this class of drugs has proved to be very effective in women and has minimal side effects. Most tricyclic antidepressants can also be used with minimal risk during lactation, but tend to have more side effects. Because after birth women seem to have an increased sensitivity to medication side effects, treatment should be initiated at a reduced dose.

Selective serotonin reuptake inhibitors are therefore the first-line medication treatment for postpartum depression. Usually, between 4 and 8 weeks are required to remit the depressive symptoms, although some women feel better after a shorter period of treatment. Selective serotonin reuptake inhibitors are considered relatively safe for breastfeeding because they generally pass into milk in a small dose (except fluoxetine, which has been identified in breast milk in high doses). Tricyclic antidepressants have not caused any known problems in breastfed babies because they don't get in the baby's blood in measurable doses (except doxepin which is not considered safe during lactation). Tricyclic antidepressants may also require 4 to 8 weeks to improve depression. Antidepressants are usually used for at least six months, first to treat postpartum depression, and then to prevent relapse. This could recommend continued treatment up to a year before its gradual withdrawal. Experts recommend long-term antidepressant treatment in women who have had three or more depressive episodes in the past.

Estrogen treatment for postpartum depression has been poorly studied. Some women that took estrogen showed an improvement in health status, however, some of them were also taking an antidepressant, so it's hard to know whether the effect is solely due to the estrogen. Estrogen therapy is still unlikely to become a common treatment for postpartum depression because it increases the risk of deep vein thrombosis and endometrial cancer. Adding progesterone reduces the risk of endometrial cancer, but is known as a trigger for postpartum depression, when administered after birth.

Light therapy is an alternative therapy using exposure to bright light (not the whole spectrum of light which includes ultraviolet rays). Typically in phototherapy, a person will have to stand before a high-intensity fluorescent lamp (between 2,500 and 10,000 lux), gradually increasing the exposure range, up to 1-2 hours every morning. Although light therapy for postpartum depression has not yet been sufficiently studied, it has proved beneficial for pregnant women and for winter depression (seasonal affective disorder), without severe side effects.

Another PPD etiological hypothesis is the omega-3 fatty acid depletion in the brain of the mother during the last three months of pregnancy, culminating in the birth. Supplementing the diet with omega-3 fatty acids had favorable results in the evolution of new mothers' emotional state.

Some studies (Hagen, Barrett 1999) conclude that PPD is not actually a mental disorder but a result of physical and emotional insecureness in mother. The symptoms of PPD can ameliorate very quickly by helping the mother to overcome these anxieties through a powerful emotional, moral, and material support from the whole family, especially from the husband.

CONCLUSIONS

- Postpartum depression is a condition commonly encountered in clinical practice.
- Although it is also described in men, this disorder has a much more significant impact in women.
- We emphasize, once again, the need for early diagnosis, which has repercussions both in the development and prognosis of the mother, and in her ability to take care of her child; knowing that the first months of a person's life are particularly important for the later evolution. In some countries (for example in Alberta, Canada) prenatal screening of all women is performed, and the emotional state of the mothers at risk is closely monitored in the following months after birth.

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