Nondrug Options May Help Ease Depression

Some types of psychotherapy are as effective as medication in treating pregnancy-related depression.

BY CARL SHERMAN
Contributing Writer

New York — Nonpharmacologic treatments are particularly worth considering when mood problems develop during pregnancy and in the postpartum period, Linda S. Mullen, M.D., said at an obstetrics symposium sponsored by Columbia University and New York Presbyterian Hospital.

Medication should not be dismissed as an option, however, and is generally preferable when symptoms are severe.

Pregnancy itself appears to be neither a time of particular mental well-being nor vulnerability; surveys find that about 20% of women suffer from mood or anxiety disorders at this time, essentially the same proportion as women in general, said Dr. Mullen, director of women's mental health at the university and the hospital.

But such difficulties clearly are more common in the postpartum period and run along a spectrum of severity from "baby blues" to psychosis.

"Postpartum blues" are extremely common, affecting 50%-85% of women. Rather than depression, typical symptoms are mood lability, anxiety, irritability, and difficulty in eating, sleeping, and caring for oneself and the baby. These symptoms may be troubling, but do not interfere markedly with functioning; they usually peak 4-5 days post partum and resolve by day 10.

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"Reassurance rather than treatment is generally enough," Dr. Mullen said. But if difficulties persist for at least 2 weeks, an evaluation for serious mood disorder is in order.

About one-fourth of women with postpartum blues later develop clinically significant depression, she said.

Postpartum depression actually can emerge any time within 2-3 months of childbirth. It is clinically indistinguishable from depression generally and may include comorbid anxiety syndromes such as panic, obsessive-compulsive disorder, or generalized anxiety.

"Many women don't come to see the physician until late; they think what they experience is a normal part of the postpartum, or feel ashamed at their difficulties in caring for their baby," Dr. Mullen said.

Unlike depression in other groups, age, marital status, education level, and socioeconomic status are not associated with increased prevalence, but marital problems, inadequate social support, and recent stressful life events are major risk factors. Women with a history of depression also are at increased risk, she said.

Treatment depends in part on severity. For mild to moderate symptoms, certain types of psychotherapy seem as effective as medication and are preferred by many women, particularly those who are breastfeeding.

Cognitive-behavioral therapy, in particular, has been shown to be as effective as fluoxetine. Interpersonal therapy, which focuses on relationship issues, has also been found efficacious in mild to moderate depression in the postpartum. "It may be especially useful for women with marital difficulties," Dr. Mullen said.

Couples therapy and group therapy are also helpful, and there is some evidence that psychoeducational groups for pregnant women at risk may prevent postpartum depression. Psychosocial management should include interventions to increase social support and help with childcare, she said.

Light therapy appears to be effective for depression during pregnancy, and may be helpful in the postpartum as well.

When medication is necessary or preferred, conventional antidepressants at standard doses are as efficacious for postpartum depression as for depression generally. Selective serotonin reuptake inhibitors are the agents of choice, and benzodiazepines may be added for concurrent anxiety, particularly in the first weeks of treatment.

The addition of psychotherapy actually makes medication more effective, Dr. Mullen said. ■

Look for Signs of Psychosis in Mother When Evaluating Infanticidal Thoughts

BY ROBERT FINN
San Francisco Bureau

Newport Beach, Calif. — When a new mother reports having infanticidal thoughts, how should one decide whether she poses an imminent danger to the child? The key is to assess several risk factors, Gagan Dhaliwal, M.D., said at the annual meeting of the American College of Forensic Psychiatry.

Dr. Dhaliwal, of the University of South Alabama, Mobile, discussed the hypothetical case of a 19-year-old woman with a 2-week-old son who is seen in an outpatient psychiatric clinic. She reports feeling depressed and lacking energy, and has a loss of appetite and frequent crying spells. She says she's not being a good mother and has thoughts of killing her son.

The mother with obsessions will attempt to suppress them and recognizes they're products of her own mind.

"First of all, we have to figure out whether these thoughts are in the context of psychosis," Dr. Dhaliwal said. Upon further questioning, the woman reported that she felt suspicious of others and cannot trust other people. She says that she hears a voice in her head saying, "do it," a command hallucination related to hurting her son.

The woman says she lives alone, is not sure of the identity of the child's father, and doesn't want to involve her family. She's concerned that her child will be taken away if she's admitted for inpatient treatment, but she agrees to take medication as an outpatient.

At this point there's sufficient cause to break confidentiality and contact the woman's family, Dr. Dhaliwal said. The family reports the woman had been taking medication for bipolar disorder but discontinued it during pregnancy.

Now the physician must answer several questions. Does the woman have a mental illness? Clearly she does, because of her previous history of bipolar disorder.

But is she imminently dangerous to her child? Should inpatient or outpatient treatment be recommended? Should she be committed involuntarily? How does one weigh the issue of mother-child privacy, compared with the governmental intrusion that would be involved in involuntary treatment? What effect would involuntary commitment have on the mother-child relationship? Is that presumably deleterious effect enough to outweigh the mother's potential dangerousness to the child?

Clearly, there's no reason to commit all mothers with aggressive or infanticidal thoughts. Studies have shown that many women post partum have obsessive thoughts about harming their children. The physician must differentiate those common obsessive thoughts from true psychosis, which involves a loss of touch with reality.

The mother with obsessions will attempt to suppress these obsessions and generally recognizes they're products of her own mind. The psychotic mother, believes the thoughts are imposed by an outside force.

In the hypothetical case, the woman's history, her command hallucinations, and her lack of insight argue for psychosis. She also has other risk factors linked with infanticide.

Among the risk factors identified in one study are maternal age less than 17 (relative risk 10.9), second or subsequent-born infants (relative risk 9.3), lack of prenatal care (relative risk 10.3), and low education levels (relative risk about 8 for women who did not complete high school) (N. Engl. J. Med. 1998;339:1211-6).

Other factors that increase the risk are substance abuse; a history of major mental illness, especially major depression or bipolar disorder; a family history of psychiatric illness; childhood abuse; self-doubt as a mother; poverty, a poor support system; and an unavailable partner

The hypothetical woman doesn't exhibit all of those risk factors. But Dr. Dhaliwal says she exhibits enough to warrant involuntary commitment. ■

For Pregnant Smokers, Cutting Back Later Is Better Than Never

Los Angeles — A pregnant smoker who cuts back just one cigarette a day in her third trimester can hope to increase her newborn's birth weight by 24 g, according to a prospective study reported at the annual meeting of the Society for Gynecologic Investigation.

"The message is, Keep at 'em. Don't stop trying to get women to reduce their smoking volume," said Ira M. Bernstein, M.D., who presented data on 160 women and their offspring.

The mothers were enrolled in a randomized, prospective trial of a voucher system designed to help pregnant women stop smoking or stay cigarette free. Dr. Bernstein of the University of Vermont, Burlington, said investigators determined a woman's smoking volume by a combination of self-reports, and measurement of urinary cotinine and exhaled carbon monoxide.

Before pregnancy, the group averaged 18.2 cigarettes a day. They had already cut down to 6.7 cigarettes per day by the time they enrolled in the study, which was at 12 weeks' gestation on average. By 28 weeks, they were down to 4.8 cigarettes daily.

All had singleton pregnancies with a mean birth weight of 3,266 g. The mean gestational age at delivery was 38.6 weeks, with 17 babies born preterm. Stepwise multivariate regression analysis found smoking in the third trimester accounted for 10% of variance in birth weight. Dr. Bernstein reported a linear relationship in which babies weighed 24 g less at birth for every cigarette their mothers smoked per day in the third trimester.

"The literature is mixed. Some data say the first trimester is critical. These data support that the third trimester is more important," he said.

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—Jane Salodof MacNeil

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