Mild Postpartum Depression: Try Nondrug Options

BY CARL SHERMAN
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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.

"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.

Recent stressful events are a major risk factor. Psychosocial management should include interventions to increase social support and help with child care.

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 breast-feeding.

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 child care, 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 makes medication more effective, Dr. Mullen said. ■