



CARE FOR KIDS



Early & Periodic Screening, Diagnosis & Treatment

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Coming Your Way

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Those individuals who are longstanding readers of the *EPSDT Care for Kids Newsletter* will recognize that this issue is a departure from previous newsletters. Earlier issues have addressed conditions of EPSDT eligible infants, children and adolescents. This issue expands the focus of the screening evaluation to include the child's environmental milieu. It addresses the mental health of a child's primary care giver. Recognition of maternal depression and a knowledge of community resources for assessment and treatment are an important component of EPSDT screening. Maternal mental health has a direct effect on the mental and physical health of a child. It may also play an important role in the child's growth, development, and general health status. While the *EPSDT Care for Kids Newsletter* will continue to focus on issues affecting the child, future issues will also explore other environmental factors that may affect that child's health and well being.

The Identification of Postpartum Depression

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The postpartum period is one of great change for both mothers and their infants. In addition to the obvious physical changes, psychological adjustment occurs as well. This is a crucial time for the development of a sound bond between the infant and the mother. Disruption of this attachment, particularly as the result of maternal depression, can have a profound effect not only on the mother, but also on her newborn and the rest of her family. For these reasons, identification and effective treatment are paramount.



Postpartum Depression

Experts agree that about one mother in ten experiences postpartum depression. Though postpartum depression most often appears within the first three months, it can develop at any time during the first year. Despite the high incidence of postpartum depression, however, it remains largely unrecognized—both by affected women and by their health care providers. In

one study, 97% of women with postpartum depression reported that they felt there was “something wrong,” but only 32% believed they were suffering from depression. Many felt their symptoms were either not severe enough to merit treatment or attributed them to family or child care difficulties. Most strikingly, only 10% discussed their symptoms with a health care professional.

Primary care providers, particularly family practitioners, obstetricians, and pediatricians, play a key role in recognizing postpartum illness. As many new

mothers will have little contact with their obstetricians after the first six weeks postpartum, it is often the physicians caring for the newborn who have the most contact with these women. They need to be alert to the signs of postpartum depression. Patients should be asked about psychological problems, or screened for postpartum depression using instruments such as the Edinburgh Postnatal Depression Scale (see “Evaluating Maternal Mental Health,” Insert, Page 1).

In the past, hormonal changes were believed to be the cause of postpartum depression, but recent research has conclusively shown that this is not true. Instead, experts now see the postpartum period as a time of psychosocial stress that may precipitate depression in some women.

This view is confirmed by evidence that links postpartum depression to such social risk factors as being unmarried and having an unplanned pregnancy.

Identification of Postpartum Depression

Women from lower social classes and with lower incomes are at higher risk for postpartum depression, as are women with poor support from their spouses and others. Preterm birth and difficulty with pregnancy and delivery are also associated with the illness.



A history of depression is clearly the greatest risk factor. A woman's risk for postpartum depression increases from about 10% to 25% if she has experienced depression before. If she has had a previous episode of postpartum depression, the risk increases to almost 50%.

Women who are depressed during pregnancy also have more than a 50% chance of postpartum depression. A family history of major depression may also increase the risk for postpartum depression.

No evidence exists for major qualitative differences between postpartum depression and other types of depression. Recognition of postpartum depression, however, is more difficult. Many of the changes that occur normally during the postpartum period are similar to those that signal depression. For example, fatigue and sleep disruption may result from the demands of the newborn, rather than from depression. Conversely, and more important clinically, women with postpartum depression who note fatigue and sleep problems may be ignored by their doctors, spouses, and family because the incorrect assumption is made that this is a "normal" development rather than a symptom of depression.

Physicians should be alert to the physical symptoms of postpartum depression while also carefully assessing psychological symptoms. These symptoms include:

- Depressed mood
- Lack of interest or pleasure in activities

- Lack of appetite or pleasure in eating
- Sleep disruption
- Fatigue or lack of motivation
- Feelings of guilt or worthlessness
- Poor concentration
- Persistent anxiety
- Thoughts of death or suicide

New mothers who are depressed often report feelings of guilt about their ability to care for their newborns, or report a lack of enjoyment, particularly with their children. Any tendency toward suicidal impulse must be carefully evaluated as well. Thoughts of harm towards the newborn, though rare, must also be assessed.

Though "official" diagnosis of depression according to the Diagnostic and Statistical Manual for Mental Disorders (DSM-IV) requires the presence of five or more symptoms over a period of at least two weeks, clinicians should not let this stand in the way of providing appropriate treatment for women who are depressed. The patient and physician must determine together whether or not the patient's symptoms are interfering with her ability to function. If this is the case, regardless of how many of the symptoms are present, treatment should be initiated.

Treating Postpartum Depression

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Antidepressants

To treat new mothers who have postpartum depression, and who are not breastfeeding, any of the commonly used medications for postpartum depression may be prescribed. If there is a history of depression, the choice of medication should be based on the woman's previous response to medication, or her family's history of response to treatment.

When considering the treatment of depression in women who breastfeed, it is important to be aware of the risks posed by untreated depression, especially the adverse effects it can have on child development (See "Maternal Depression Can Profoundly Affect a Child's Development," Insert Page 2). The risks of medication and the benefits of treatment should be carefully weighed. Experts agree that moderate to severe depression in nursing mothers should be treated with medication. Current data suggests that the use of tricyclic antidepressants (TCAs) and the selective serotonin reuptake inhibitors (SSRIs) is relatively safe for the breastfeeding infant. Though fewer women have been treated postpartum with the new generation antide-

pressants, these medications also appear to be relatively safe during breastfeeding. Electroconvulsive therapy can be safely used for women with psychotic depression, and for those who do not respond to other treatments.

In sum, the current clinical consensus is that antidepressants can be used with breastfeeding women who have moderate to severe depression. Because commonly used antidepressant medications appear safe, the guidelines for selection of medication described above (e.g., previous response or family history of response to treatment) should be used. Supplementation of breastfeeding with bottle feeding during times of peak exposure may also reduce risks to infants.

Psychotherapy

Despite data supporting the relative safety of antidepressant medications during breastfeeding, many women are wary of their use. In one study, only 20% of women with postpartum depression said that they would consider using antidepressant

medications. Psychotherapy is an effective alternative for women who do not want to use medications while breastfeeding.



Psychosocial treatments for postpartum mood disorders fall into two categories:

1. Preventive treatments. These aim to prevent depression. They begin during pregnancy or soon after the baby is born.
2. Psychosocial intervention for women with postpartum depression.

Research suggests that the use of preventive measures with women who are not at high risk is an ineffective use of resources. However, the value of community screening has been clearly

continued on page 4

Evaluating Maternal Mental Health

Mother's name _____ Patient ID _____

Date: Month _____ / Day _____ / Year _____ Total _____

You have recently had a baby, and we would like to know how you are getting along. Please put an X by the answer that comes closest to describing how you have been feeling during the past 7 days.

(Please don't mark the answer that only tells how you are feeling today.)

During the past 7 days:

1. I have been able to laugh and see the funny side of things.
 0 As much as I always could.
 1 Not quite so much now.
 2 Definitely not so much.
 3 Not at all.
2. I have looked forward with enjoyment to things.
 0 As much as I ever did.
 1 A little less than I used to.
 2 Definitely less than I used to.
 3 Hardly at all.
3. I have blamed myself unfairly when things went wrong.
 0 Yes, most of the time.
 1 Yes, some of the time.
 2 Not very often.
 3 No, never.
4. I have been anxious or worried for no real reason.
 0 No, not at all.
 1 Hardly ever.
 2 Yes, sometimes.
 3 Yes, very often.
5. I have felt scared or panicky for no real reason.
 0 Yes, quite a lot.
 1 Yes, sometimes.
 2 No, not much.
 3 No, not at all.
6. Things have been too much for me.
 0 Yes, most of the time I haven't been able to cope at all.
 1 Yes, sometimes I haven't been coping as well as usual.
 2 No, most of the time I have coped quite well.
 3 No, I have been coping as well as ever.
7. I have been so unhappy that I have had trouble sleeping.
 0 Yes, most of the time.
 1 Yes, sometimes.
 2 Not very often.
 3 No, not at all.
8. I have felt sad or miserable.
 0 Yes, most of the time.
 1 Yes, quite often.
 2 Not very often.
 3 No, not at all.
9. I have felt so unhappy that I have cried.
 0 Yes, most of the time.
 1 Yes, quite often.
 2 Only once in awhile.
 3 No, never.
10. I have thought of hurting myself.
 0 Yes, quite often.
 1 Sometimes.
 2 Hardly ever.
 3 Never

See page 7 for information on interpreting results.

FACT SHEET on *Maternal Depression*

Risk factors for postpartum depression

- Personal history of depression
- Family history of depression
- Unplanned pregnancy
- Poor support from partner or no partner
- Depression during pregnancy
- Complications during pregnancy or pre-term birth
- Poor social support

Symptoms of postpartum depression

- Depressed mood
- Lack of interest or pleasure in activities
- Lack of appetite or pleasure in eating
- Sleep too much, or can't sleep at all
- Fatigue or apathy
- Feelings of guilt or worthlessness
- Poor concentration, forgetfulness
- Persistent anxiety
- Thoughts of death or suicide

Maternal depression is common

<i>Type</i>	<i>Percent of women affected</i>	<i>Description</i>
Prepartum depression	10%	Chronic depression
Baby blues	40 to 70%	An intense feeling of letdown that begins within a few weeks of birth, and then subsides
Postpartum depression	10 to 20%	Can begin any time during the year following childbirth, continues for a longer time and is more intense than "baby blues"
Postpartum psychosis	.01% (1/1000 mothers)	Can begin any time during the first year after childbirth; a break with reality that resembles manic depression and may include hallucinations and delusions.

Maternal depression can profoundly affect a child's development

Infants

whose mothers have depression may:

- Be less active
- Be fussier
- Be less responsive to others
- Be slower to walk
- Have higher heart rates and lower vagal tone
- Vocalize less frequently
- Weigh less

Toddlers

whose mothers have depression may:

- Be at higher risk for affective disorder
- Exhibit problem behaviors
- Have attention problems
- Have poor peer relationships
- Have problems with self-control
- Develop symptoms that mimic the mother's depressed behavior

At 36 months,

without treatment, these youngsters often:

- Are less cooperative
- Are more aggressive
- Continue to show brain activity that suggests chronic depression
- Demonstrate less verbal comprehension
- Have lower expressive language skills
- Have more problem behaviors
- Perform more poorly on measures of school readiness
- Will demonstrate lower cognitive ability at four years of age

Successful treatment matters.

In one study, when remission of maternal depression occurred within 6 months of a child's birth, children had no cognitive delay or emotional symptoms at one year of age.

Sources:

American Psychological Association Public Communications, at <http://www.apa.org/releases/mom.html>

G. Dawson et al. (1994). "Social influences on early developing biological and behavioral systems related to risk for affective disorder," *Dev & Psychopath* 6:759-779.

NIH News Alert, <http://www.nichd.nih.gov/new/releases/depression.htm>



demonstrated. Women who are depressed can be identified either through health clinics or by visiting health care providers. Once identified, such women are often willing to engage in acute treatment. Given the implications of untreated postpartum depression for women and their children, community screening is well worth the effort.



In contrast to preventive measures, treatment of an acute episode of depression with short-term psychotherapy is often beneficial. Interpersonal psychotherapy, using a time-limited treatment of 12 to 16 weeks, is very effective in reducing depressive symptoms. Cognitive therapy, though not yet tested as a treatment for postpartum depression, is also likely to be helpful. Studies comparing the use of psychotherapy with medications for postpartum depression, and evaluating the use of psychotherapy for women who have depression during pregnancy, are currently underway at the University of Iowa.

Recommendations for Treatment of Postpartum Depression

Mild to moderate depression

- Interpersonal psychotherapy
- cognitive therapy

Moderate to severe

- Serotonin re-uptake inhibitors (Fluoxetine, Sertraline, Paroxetine)
- Tricyclic antidepressants (Imipramine, Nortriptyline, and others)
- New generation antidepressants (Venlafaxine, Bupropion, and others)

Severe depression

- Electroconvulsive therapy

Postpartum depression is a serious illness that affects women, their children, and their families. Health care providers can easily screen their patients for this disorder by asking directly about its symptoms. An instrument such as the Edinburgh Postnatal Depression Scale also works well, and a Maternal Mental Health Survey based on this questionnaire is provided below (see Insert Page 1). Safe, effective treatments, including antidepressant medications and psychotherapy, are available.

Resources

Antidepressant treatment during breast-feeding, by KL Wisner et al. (1996) *AmJPsychiat* 153:1132-1137.

Interpersonal psychotherapy...,” by S. Stuart (1999). In *Postpartum Psychiatric Disorders*, ed. L. Miller.

Postpartum Depression: Causes and Consequences, by MW O’Hara (1994).

Postpartum Health Research Laboratory, University of Iowa; phone 319/335-0307.

Evaluating Maternal Mental Health

The scale used in “Evaluating Maternal Mental Health” on Insert Page 1 is adapted with very few changes from the “Edinburgh Postnatal Depression Scale,” presented in “Detection of postnatal depression: The Edinburgh Postnatal Depression Scale,” by JL Cox et al. (*British Journal of Psychiatry* 1987, 150:782-786). This 10-question, self-report scale has shown both reliability and validity.

Each question on the survey allows responses that earn from zero to 3 points (questions 3 and 5 through 10 are reverse scored). These points are totaled to give an overall score. A score of 12-13 is considered to indicate depression.

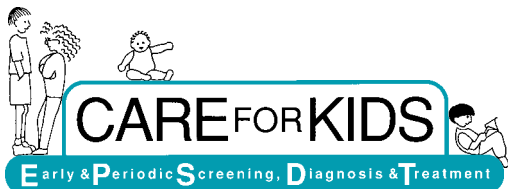
What's in this issue

Coming Your Way	1
The Identification of Postpartum Depression	2
Treating Postpartum Depression	4
Evaluating Maternal Mental Health	Insert Page 1
Fact Sheet on Maternal Depression	Insert Page 2

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If you have questions about **clinical issues** and EPSDT Care for Kids services, please call
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