Perinatal depression

by Dr. Marlin Mills

Suicide is the 10th leading cause of death worldwide, suicide rate of 11 per 100,000 pregnancies with previous suicidal attempt as greatest risk factor (other risks include childhood trauma, substance abuse, means available and plan) with protective factors of family support, other children, religion.

In women with history of antenatal depression, effective to continue treatment of antenatal depression through pregnancy and postpartum, aim to maximize maternal wellness as best as possible, in patients who have historically been on SSRI continue what has worked with counseling of risks but likely still of benefit as relapse risk is high.

DSM criteria for postpartum depression of major depressive episode with postpartum onset within first 4 weeks postpartum, screening (Edinburgh) is recommended for all women postpartum. To note, in women taking an SSRI the greatest risks of suicide thinking or behavior is within first few months.

If a postpartum patient is suicidal, ensure a sitter, alert the charge nurse, seek assistance from crisis center/psychiatrist.

In regard to postpartum psychosis, 100 times more common in mothers with bipolar disorders with higher recurrence with future subsequent pregnancies.

Can be confused with postpartum OCD but to distinguish, mothers with OCD find their thoughts/compulsions to be intrusive whereas mothers with postpartum psychosis aren't alarmed/disturbed. Onset of first days postpartum to 2 weeks, often see hallucinations, flat affect.

Tips:

- Gather collaborative data from nursing and other providers,
- screen for suicide in addition to depression,
- ask about access/means,
- consult psych

Local contracts: 1-800-944-4773 (GET-HELP) Hoag Women's Health Initiative website