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Psychopharmacology for the Clinician

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Psychopharmacology for the Clinician

The information in this column is not intended as a definitive treatment strategy but as a suggested approach for clinicians treating patients with similar histories. Individual cases may vary and should be evaluated carefully before treatment is provided. The patient described in this column is a composite with characteristics of several real patients.

Mixed depression in the postpartum period: diagnostic and treatment issues

A 20-year-old married woman presented with a history of feeling depressed since the birth of her first child 3 weeks earlier. She had an uneventful pregnancy and delivered a healthy child, but felt she was not bonding with the newborn. On questioning, she reported loss of interest, crying spells, decreased need for sleep, reduced appetite, poor concentration, guilt, increased goal-directed activity and racing thoughts, but she denied any thoughts of harm to herself or to the newborn. She had no history of psychiatric illness and did not have any current symptoms of psychosis, anxiety disorder or substance use disorder. She reported that her mother has bipolar disorder. Physically, the patient was healthy, and blood work showed normal complete blood count and thyroid functioning. She agreed to consider drug treatment, but she hoped to continue breastfeeding.

Diagnostic confirmation should be the first step in the management of this patient's depression. Postpartum depression is a heterogeneous condition that includes a mixture of depressions with different etiologies, different clinical profiles and different responses to treatment. Most (60%) women experience onset of depression during or before pregnancy rather than in the postpartum period.[1] Our patient presented with predominantly depressive symptoms and with at least 3 manic symptoms, including increased goal-directed activity, racing thoughts and decreased need for sleep. Thus, she met the DSM-5 diagnostic criteria for major depressive disorder with mixed features specifier. The specifier requires the presence of at least 3 hypomanic or manic symptoms that do not overlap with symptoms of major depression.[2] A differential diagnosis of bipolar disorder should be considered because about 22% of women with postpartum depression actually have bipolar disorder,[1] but our patient did not have any hypomanic or manic episodes. However, certain clinical features, including younger age at illness onset, family history of bipolar disorder, postpartum onset and the presence of manic features in the current episode of depression, suggested that she would be at risk for bipolar disorder.[3,4]

Treatment options include psychotherapy and pharmacotherapy. Psychotherapy is generally recommended for mild to moderate postpartum depression, whereas pharmacotherapy alone or in combination with psychotherapy is usually reserved for moderate to severe postpartum depression. Antidepressants are commonly used to treat postpartum depression, but should be used with caution in patients with a first episode of depression in the postpartum period and/or family history of bipolar disorder.[3] There are no controlled trials of mood stabilizers in women with postpartum depression. Compatibility of the selected drug with breastfeeding and its effectiveness in mixed depression should be an important consideration in our patient's case. The presence of subsyndromal manic symptoms indicates that she may be at risk for treatment-emergent mania following treatment with antidepressants.[5,6] Lithium is not particularly effective in patients with mixed depression, but it can be used cautiously during lactation with attention to the infant's hydration and monitoring of renal and thyroid function. Lamotrigine can be efficacious in some patients with depression but it takes at least 4–6 weeks to reach the optimum dosage of lamotrigine. Owing to its efficacy in patients with mania and depression, a trial of quetiapine is a good option. There are no studies of atypical antipsychotics in the management of postpartum depression, but quetiapine is effective in the management of both unipolar and bipolar depressions.[7] The American Congress of Obstetricians and Gynecologists guidelines list quetiapine use as possibly hazardous during lactation.[8] Lamotrigine should be used cautiously because of concerns about skin rash in the infant after exposure through breastfeeding.[9] Psychoeducation should incorporate a discussion of the patient's diagnosis, treatment plan and expected outcome. Help with nocturnal infant care should be recommended to minimize the patient's sleep disruption. Once the patient's condition is stable, issues such as parenting skills and mother–infant bonding should be addressed.

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Psychopharmacology for the Clinician columns are usually based on a case report that illustrates a point of interest in clinical psychopharmacology. They are about 650 words long. Columns can include a bibliography which will be available only on the journal website.

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