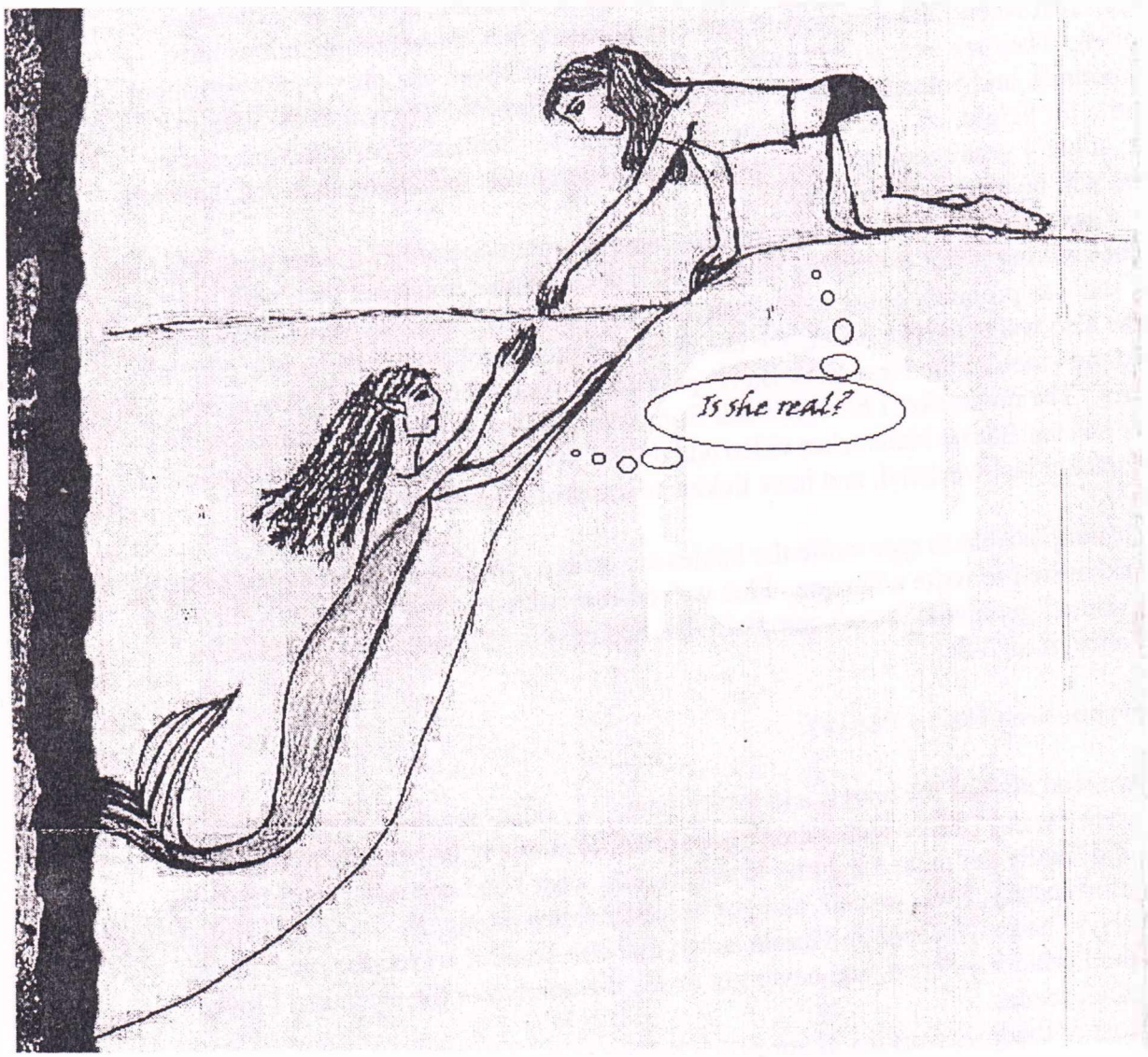
Passages #11



Passages #11

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There be toddlers

The babies turned a year old October 4, and are walking, so they are officially toddlers. Just when I thought my life was complicated, now those complications have multiplied. They are excessively cute. At their one year check ups, they each were about 17 3/4 pounds, and Samantha was 2 inches taller than Haydon! He was at the 75th percentile for height, and she was at the 95th percentile. Samantha definitely takes after Cassia; at her 4 year check up, she was at the 90th percentile for height, too. All these tall children will be towering over me.

Cassia went to a little kid basketball game to watch one of her friends play, and came back asking if she could play basketball. I was tempted to tell her that, with her height, she was probably going to be forced to play basketball, whether she wanted to or not! She also wants to take ballet; she has become transfixed by the Nutcracker. She has watched the video of the New York Ballet production with McCaughley Culkin about 300 times. The nutcracker I brought back from Germany is her constant companion, and now she has the Barbie Nutcracker video and dolls. We went to an amateur production of the Nutcracker last weekend, and have tickets to the professional production this Saturday.

It's impossible to type while the babies are awake. And when they've gone to bed, I'm too exhausted to write a fanzine. Plus we've been so busy at work; I'm worn out every evening when I get home. I can't complain that business is so good; I just wish I had a little balance in my life.

Has everyone seen Harry Potter?

I've read all 4 of the books, and loved them. My only regret is that they weren't around when I was 11 years old! I didn't get to see the movie at its opening November 16, but I did finally get to go the 24th. It was exactly what I had hoped for; faithful to the book. Unfortunately, I was on call, and got beeped 3 times during the 2 1/2 hour film. (Don't worry; I had my beeper on vibrate, so no one else heard it.) I missed most of the scene in the Forbidden Forest, and never got to see the unicorn or the centaurs. I loved the Quidditch scenes.

Most of the girls working at our office belong to fundamentalist churches. We had a debate over lunch about the propriety of Harry Potter. They honestly believe that kids reading about witchcraft in Harry Potter are in danger of falling into Satanism. They're supposed to be getting me a copy of the sermon their preacher gave condemning

Harry Potter. I'm sorry, but I don't see it. A quote from our local freebie newspaper: "-You know you've arrived as a children's author when you've angered the religious right.-"

Speaking of working....

Since I haven't had the energy to do a good zine, I thought I would risk boring you with an article I wrote for work. We publish this newsletter called "Clinical Updates" and it was my turn to write it.

Postpartum Depression

Postpartum depression (PPD) achieved national attention in June 2001 with the headlines describing Andrea Yates and her murder of her 5 children.[1] While most cases of postpartum depression are much less dramatic, it is still an insidious problem that affects at least one in ten new mothers, and in some populations as much as one in four. While PPD causes personal suffering and decreases the quality of life of the women involved, it also affects their partners and the quality of their close relationships, and it can have significant long-term effects on the children's cognitive and emotional development.[2]

Even though PPD is a relatively common problem, women who are affected feel socially stigmatized and ashamed.[2] They may view PPD as a personal weakness and not seek help.[3] In fact, up to 70% of women experiencing depressive symptoms after delivery never seek or receive help. However, major depression is a medical condition and it can be treated successfully. Thus obstetricians should be aware of the entity and proactive in assessing patients and diagnosing PPD in order to provide early intervention and treatment.

Depressive disorders are a group of clinical conditions characterized by a disturbance of mood, a loss of sense of control and self-esteem, and intense mental, emotional, and physical anguish. PPD is divided into 3 main types: "the blues", or baby blues, postpartum depressive disorder, and postpartum psychosis[1].

Postpartum blues or "baby blues" can affect 50-80% of new mothers, usually between postpartum days 1-5. Primary symptoms include fatigue, tearfulness, insomnia, irritability, inability to concentrate, and depressed affect. The "blues" are self-limited and almost always resolve within 10 days with reassurance[1].

Postpartum psychosis is very rare, and is probably what affected Andrea Yates[1]. As with any organic brain syndrome, this is a formal thought disorder, and the patients can manifest hallucinations or delusions. Primary symptoms include extreme confusion, distractibility, and disorientation. Onset occurs rapidly, usually over a 24-72 hour period, and usually in the first month after delivery. The risk for infanticide is about 4%[1]. The patient may experience command hallucinations to kill the infant or have delusions that the infant is possessed.[4]

Postpartum depressive disorder (PPD) affects 10-30% of women, and can begin as early as 2 weeks, or as late as 12 months after delivery.[1] Diagnostic criteria for PPD are the same as for a major depressive disorder[1]. Identifying risk factors for PPD enables the

obstetrician to initiate intervention early, hopefully before the mood disorder becomes disabling[2]. A recent meta-analysis identified 13 significant predictors of PPD.

Predisposing factors for PPD include a genetic predisposition, history of Premenstrual Syndrome (PMS), and a perinatal loss[2]. High rates of depression are seen in victims of domestic violence. Mothers of young children are particularly vulnerable to depression, and the rate of depression is directly proportional to the number of children in the home.

Depression may present either as a disturbance of mood or somatic complaints, such as chronic fatigue or chronic pelvic pain. 10-15% of major depressive conditions are associated with medical diagnoses or other conditions such as substance abuse, eating disorders, or concurrent medications[2]. In particular, subclinical hypothyroidism can present with depressive symptoms[5]. These conditions should be addressed first,

A simple depression screening scale is useful in the diagnosis[6]. The Beck Depression Inventory is a self-administered questionnaire involving 21 statements designed to give likelihood that the patient is depressed.

TREATMENT

First, associated medical illnesses and other conditions as mentioned above should be treated, remembering that early intervention provides the greatest chance for successful treatment[3]. If depression persists, medical therapy has been shown to be effective for PPD. The class of antidepressants called SSRI's (selective serotonin reuptake inhibitors) is commonly used by primary care physicians due to their minimal anticholinergic side effects and the fact that they do not tend to cause weight gain. They are not associated with cardiac arrhythmias, and unlike monoamine oxidase inhibitors (MAO's, such as St. John's Wort) they are not lethal in overdose. They can be associated with nausea, sexual dysfunction, and drug interactions. Three SSRIs, sertraline (Zoloft), paroxetine (Paxil), and fluvoxamine (Prozac) have been studied in nursing mothers and have been shown to produce minimal exposure the infant, with no adverse sequelae noted[7].

Psychotherapy should be considered for patients with mild to moderate depression[3]. Patients should be referred in cases of an incomplete response to medications, or for those whom medications are either contraindicated or unacceptable. The obstetrician should develop a working relationship with a psychiatrist. Support groups are also helpful.

It is important to recognize and treat PPD to prevent unnecessary anguish or possible long-term sequelae to the child[2]. It is helpful to recognize predictors and predisposing conditions for PPD, and to administer a depression screening scale to identify patients. It is necessary to distinguish between a grief reaction, which can occur after a loss, is generally self-limiting, and self-esteem is preserved. In major depression, changes in sleeping patterns, appetite, energy, and mood persist, along with a loss of self-esteem[3].

In summary, patients should be educated that PPD is a medical illness amenable to therapy, and it is not a sign of weakness or character deficiency. Recurrences are common. SSRI's, the mainstay of treatment, are well tolerated[3].

Diagnostic Criteria for Major Depressive Episode[1]

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.
Note: Do not include symptoms that are clearly due to a general medical condition, or mood-incongruent delusions or hallucinations.
   (1) Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful)
   (2) Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others)
   (3) Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. Insomnia or hypersomnia nearly every day
   (4) Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)
   (5) Fatigue or loss of energy nearly every day
   (6) Feeling of worthlessness or excessive or inappropriate guilt (which may by delusional) nearly every day (not merely self-reproach or guilt about being sick)
   (7) Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others
   (8) Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

B. The symptoms do not meet criteria for a Mixed Episode.

C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).

E. The symptoms are not better accounted for by Bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.

Postpartum Onset Specifier

Symptoms that are common in postpartum-onset episodes, though not specific to postpartum onset, include fluctuations in mood, mood lability, and preoccupation with infant well-being, the intensity of which may range from overconcern to frank delusions. The presence of severe ruminations or delusional thoughts about the infant is associated with a significantly increased risk of harm to the infant.

Predictors of PPD[2]

Prenatal depression
Low self esteem
Childcare stress
Prenatal anxiety
Life stress
Poor social support
Unstable marital relationship
History of previous depression
Colicky infant temperament
Maternity blues
Unwed marital status
Low socioeconomic status
Unplanned/unwanted pregnancy

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