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Research article

Postpartum depression and thyroid dysfunction—should pregnant women be screened for thyroid disorders?

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Abstract

The relationship between thyroid dysfunction and postpartum depression has been investigated for quite some time now, but no consensus has been reached regarding the need for screening for thyroid function during pregnancy. This paper aims to investigate whether thyroid hormone screening in pregnancy might contribute to the diagnosis of postpartum depression.

Depression was assessed using the Edinburgh Postnatal Depression Scale (EPDS) - one of the most widely used measures in detecting postpartum depression and anxiety. Thyroid function was measured using the commonly recommended thyroid laboratory tests.

A structured questionnaire was given to 61 patients closely monitored during their pregnancy and at least one year after giving birth, including for thyroid and depression disorders. The questionnaire was completed anonymously online by the patients and had three sections: one containing the EPDS questions, one assessing thyroid function, and a demographic section.

The interdependency between thyroid and depression was analyzed in SPSS using the Pearson chi-square test of independence. The results show no statistically significant relationship between thyroid dysfunction and depression. In other words, women suffering from thyroid dysfunctions have no greater rate of depression compared to women without thyroid dysfunction. As a result, it screening for thyroid disorders during pregnancy may not provide relevant information for detecting postnatal depression.

Keywords

: Postpartum depression (PPD), thyroid dysfunction, Edinburgh Postnatal Depression Scale (EDPS)

Highlights

- ✓ This study found no difference in postpartum depression for women with thyroid dysfunction compared to women without thyroid dysfunction.
- ✓ The study pinpoints the need for appropriate and constant assessment of postpartum depression in Romania and the creation of an appropriate medical structure to identify and mitigate the risks of postpartum depression.

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Introduction

Postpartum depression (PPD) is defined as a non-psychotic depressive episode that can last from one month up to one year after birth (1). If left undiagnosed, the disorder may have negative consequences, on both the mother and the child. It is estimated that PPD affects 10 to 15% of new mothers (2, 3). Mothers' postpartum mood disturbance may lead to an increased risk of affecting the child's cognitive capacity, social skills, and long-term affections. (4). However, less than half of postnatal depression cases are detected through routine clinical practice (5).

Thyroid disorders are among the most common endocrine pathologies during pregnancy and the postpartum period. The prevalence of thyroid dysfunction in postpartum ranges between 1.1 % and 16.7 % across the country (6). Studies have shown that maternal thyroid autoimmunity was associated with postpartum depression (7). The majority of women predisposed to develop postpartum thyroiditis have subclinical thyroid autoimmune disease manifestations early in the pregnancy (e.g. hyperemesis gravidarum). At the postpartum visit, thyroiditis does not necessarily manifest clinically and thus it is important that physicians be aware of the risks of thyroid disorders.

Nevertheless, in everyday practice there are insufficient data to recommend universal screening for thyroid in pregnancy, and, in the absence of clinical symptoms, treatment is unnecessary (8, 9).

In Romania, screening for neonatal hypothyroidism has been performed at birth since 1979. The incidence of hypothyroidism is 1 in 3,409 new-born babies (10).

Currently, several postpartum screening tools are used for identifying depression, such as Hamilton Depression Rating Scale – HDRS, developed by Hamilton in 1960; Cronhom – Ottoson scale, also introduced in 1960; Melancholia Scale – introduced by Bech and Rafaelse in 1980; Montgomery – Asberg Depression Rating Scale – MADRS, developed in 1976, as well others, many based on the Hamilton scale.

The Edinburgh Postnatal Depression Scale (EDPS) was developed by Cox and collaborators in 1987 (11). The aim of the scale was to identify women suffering from postpartum depression. The scale was initially tested in Edinburgh and Livingston and consisted of 10 questions with responses on a Likert scale (see Figure 1). Studies conducted on the scale's validity showed that almost 92 percent of women suffering from postpartum depression are correctly diagnosed using the EDPS. However, the scale is used only as a screening tool and not as a diagnostic tool in the public health system, i.e., a diagnosis of depression should be made only by specialized healthcare providers. Nevertheless, the EPDS scale is a useful tool for providing preliminary information.

The objective of this article is to test whether there is a relationship between thyroid dysfunction (diagnosed

before, during, or after pregnancy) and postnatal depression.

The analysis is performed based on questionnaires completed by mothers one year or more after birth, retrospectively assessing their postpartum depression at 3 months after birth, based on the Edinburgh Scale and also answering questions related to thyroid disorders. The aim is to assess if patients known for thyroid pathologies or those who later discovered their thyroid problems are more likely to suffer from postpartum depression, thereby establishing a link between the two disorders. If so, the need for screening for thyroid disorders during pregnancy might be justified.

Materials and Methods

We performed a structured questionnaire-based study on 61 women at least one year after birth, our goal being to assess the relationship between thyroid dysfunction and postpartum depression.

The two variables - thyroid function and postpartum depression - were measured as follows: the first used T3, T4, and TSH laboratory tests; the second, depression, was assessed using the Edinburgh Postnatal Depression Scale – EDPS.

Women were tested during pregnancy for thyroid function (T3, T4 and TSH) and monitored for at least one year after birth (including thyroid dysfunction and psychiatric disorders). We included only women with full-term birth; we excluded patients with high risk pregnancies: prematurity, malformations, etc. that might lead to depression. Patients with thyroid carcinoma or undergoing hormonal replacement therapy were excluded as well.

The questionnaire was distributed to 65 women in February 2017, and 61 valid anonymous surveys were introduced in the data base. Consent forms for the use of personal data in this study were signed beforehand.

The questionnaire was structured in three sections: one containing socio-demographic questions, one assessing the thyroid function, and one regarding self-assessed well-being based on Edinburg depression Scale – completed one year or more after birth regarding their state at 3 months after giving birth.

Regarding demographic aspects, respondents were mainly from Bucharest and neighboring counties. At the time of child birth, the youngest mother was 21 and the oldest 41 years. The average mother's age at delivery was 30.6 years – close to the median age of 30 years (indicating that half of the mothers are 30 years old or younger and the other half are 30 years old or more).

The section related to thyroid gland functioning was summarized in the following three variables:

- Variable 1 – a variable showing if the patient had or did not have thyroid issues before pregnancy;
- Variable 2 – a variable showing if the patient underwent or did not undergo treatment for the thyroid before pregnancy;
- Variable 3 – a variable showing if the patient underwent or did not undergo treatment for the thyroid during pregnancy or immediately after (in the first year after giving birth).

The last of the three sections was based on the Edinburgh Postnatal Depression Scale (EPDS). This test to evaluate postpartum depression consists of ten questions answered by the mother. Responses have four possibilities, scored from 0 to 3, with overall scores linked to the severity of the symptoms. The cut-off scores for depression have typically ranged from 9 to 13 points. Based on the score, the patients in our sample were included in one of the two categories: With or Without depression, with 10 points serving as the cut-off point).

The EPDS results were cross-tabulated against the three thyroid-related variables. The Pearson Chi squared test was used to test whether depression (Yes/ No based on the EPDS scale) and thyroid dysfunction (hypo- or hyperthyroidism - before or after pregnancy) are associated. This test was chosen as each of the two/paired variables are measured on a categorical or ordinal scale, and the two variables consist of two or more categorical independent groups. Data analysis was performed using SPSS Software.

Results

The assessment of depression based on the ten EPDS questions is summarized in Figure 1. Each question is separately presented as well as an overall distribution of responses.

Responses to questions 1, 2, and 4 are scored 0, 1, 2, or 3 according to increased severity of the symptom. The rest of the questions are marked with an asterisk (*) meaning that they were reverse scored (i.e. 3, 2, 1, and 0).

| | | | | | |
|--|----------------|------------|---|----------------|------------|
| Q1 Was able to laugh and see the funny side of things | No of patients | Percentage | Q6* Things have been getting on top of me | No of patients | Percentage |
| As much as I always could | 34 | 55.7% | Yes, most of the time I haven't been able to cope at all | 18 | 25.0% |
| Not quite so much now | 17 | 27.9% | Yes, sometimes I haven't been coping as well as usual | 18 | 25.0% |
| Definitely not so much now | 9 | 14.8% | No, most of the time I have coped quite well | 18 | 25.0% |
| Not at all | 1 | 1.6% | No, have been coping as well as ever | 18 | 25.0% |
| Q2 Have looked forward with enjoyment to things | No of patients | Percentage | Q7* Have been so unhappy that I have had difficulty sleeping | No of patients | Percentage |
| As much as I ever did | 44 | 72.1% | Yes, most of the time | 5 | 8.2% |
| Rather less than I used to | 13 | 21.3% | Yes, sometimes | 8 | 13.1% |
| Definitely less than I used to | 4 | 6.6% | Not very often | 13 | 21.3% |
| Hardly at all | 0 | 0.0% | No, not at all | 35 | 57.4% |
| Q3* Have blamed yourself unnecessarily when things went wrong | No of patients | Percentage | Q8* Have felt sad or miserable | No of patients | Percentage |
| Yes, most of the time | 16 | 26.2% | Yes, most of the time | 4 | 6.6% |
| Yes, some of the time | 21 | 34.4% | Yes, quite often | 8 | 13.1% |
| Not very often | 10 | 16.4% | Not very often | 18 | 29.5% |
| No, never | 14 | 23.0% | No, not at all | 31 | 50.8% |
| Q4 Have been anxious or worried for no good reason | No of patients | Percentage | Q9* Have been so unhappy that I have been crying | No of patients | Percentage |
| No, not at all | 20 | 32.8% | Yes, most of the time | 5 | 8.2% |
| Hardly ever | 18 | 29.5% | Yes, quite often | 6 | 9.8% |
| Yes, sometimes | 19 | 31.1% | Only occasionally | 15 | 24.6% |
| Yes, very often | 4 | 6.6% | No, never | 35 | 57.4% |
| Q5* Have felt scared or panicky for no very good reason | No of patients | Percentage | Q10* The thought of harming myself has occurred to me | No of patients | Percentage |
| Yes, quite a lot | 5 | 8.2% | Yes, quite often | 1 | 1.6% |
| Yes, sometimes | 12 | 19.7% | Sometimes | 1 | 1.6% |
| No, not much | 15 | 24.6% | Hardly ever | 4 | 6.6% |
| No, not at all | 29 | 47.5% | Never | 55 | 90.2% |

Figure 1. Assessing depression - distribution of answers to the EPDS questions. Question 10 is important due to signaling the potential suicidal behavior. The data show that two out of the 61 patients often thought about harming themselves. The total score is determined by summing up the scores for each of the 10 items. The score distribution is presented in Figure 2.

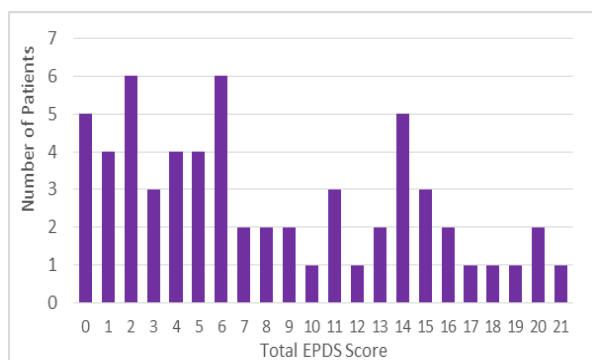


Figure 2. EPDS score distribution for the group of patients

According to the literature, the cut-off score is between 9-13 – higher values signaling the possibility of post-partum depression. In our sample, a score of 10 was considered the cut-off score, thus erring on the side of caution. The chart below shows that, although most of the patients’ scores are on the lower side of the scale, 38% scored above 10, indicating symptoms of postpartum depression (see Figure 3).

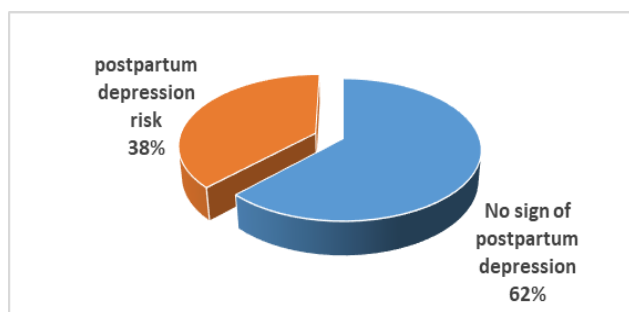


Figure 3. The postpartum depression risk structure of patients

Responses to questions assessing thyroid disorders before, during, or after pregnancy are summarized in Table 1.

| | No | Yes | Don't Know/Don't answer |
|---|-------|-------|-------------------------|
| Variable 1: thyroid issues before pregnancy | 75.4% | 11.5% | 13.1% |
| Variable 2: treatment for thyroid before pregnancy | 85.2% | 11.5% | 3.3% |
| Variable 3: treatment for thyroid during pregnancy or immediately after (in the first year after birth) | 85.2% | 13.1% | 1.6% |

Of the 61 mothers, only seven had had thyroid-related medical issues before pregnancy and consequently underwent appropriate treatment. The number increased

to eight with thyroid disorders who underwent treatment during or after pregnancy.

We cross-tabulated these two variables to assess their interdependency, with results presented in Figure 4. None of the three analyses were significant. Consequently, these two variables, postpartum depression and thyroid disorder, occurred independently of one another.

Figure 4. SPSS Results of Pearson chi-square test of independence

| | | Before pregnancy thyroid problems? | | | Total |
|---------------------|-----|------------------------------------|-----|------------|-------|
| | | No | Yes | Don't know | |
| EDS_Depression_3mo* | No | 29 | 4 | 5 | 38 |
| | Yes | 17 | 3 | 3 | 23 |
| Total | | 46 | 7 | 8 | 61 |

| | Value | df | Asymp. Sig. (2-sided) |
|------------------------------|-------------------|----|-----------------------|
| Pearson Chi-Square | .090 ^a | 2 | .956 |
| Likelihood Ratio | .089 | 2 | .956 |
| Linear-by-Linear Association | .000 | 1 | .985 |
| No. of Valid Cases | 61 | | |

| | | Thyroid treatment before pregnancy | | | Total |
|----------------------|-----|------------------------------------|-----|----------------------|-------|
| | | No | Yes | Don't know /Not sure | |
| EDS_Depression_3 mo* | No | 33 | 4 | 1 | 38 |
| | Yes | 19 | 3 | 1 | 23 |
| Total | | 52 | 7 | 2 | 61 |

| | Value | df | Asymp. Sig. (2-sided) |
|--------------------|-------------------|----|-----------------------|
| Pearson Chi-Square | .238 ^a | 2 | .888 |
| Likelihood Ratio | .233 | 2 | .890 |
| No. of Valid Cases | 61 | | |

| EDS _Depression_3 months * Treatment pregnancy or after Cross-tabulation | | | | | |
|---|-----|--------------------------------|---|---|-------|
| | | Treatment pregnancy + after | | | Total |
| | | 0 | 1 | 9 | |
| EDS _Depression _3 mo | No | 33 | 4 | 1 | 38 |
| | Yes | 19 | 4 | 0 | 23 |
| Total | | 52 | 8 | 1 | 61 |

| Chi-Square Tests | | | |
|--------------------|--------------------|----|-----------------------|
| | Value | df | Asymp. Sig. (2-sided) |
| Pearson Chi-Square | 1.150 ^a | 2 | .563 |
| Likelihood Ratio | 1.476 | 2 | .478 |
| No. of Valid Cases | 61 | | |

Discussion

The results demonstrate the complexity of postpartum depression. From the total of 61 women, 23 had a score of 10 or more out of a possible 30 points. In other words, 38% of the patients presented signs of postpartum depression three months after giving birth. Moreover, the last question in the EPDS scale identified two patients who exhibited suicidal risks.

In terms of thyroid disorders, all patients were monitored during pregnancy. Seven (11.5%) had had pre-pregnancy thyroid disorders. One patient was diagnosed and treated for thyroid disorders during pregnancy and displayed no signs of depression.

From the seven patients diagnosed with pre-pregnancy disorders, three had an EPDS score indicating depression signs, and four were not affected by postpartum depression.

Although the interaction mechanism between thyroid dysfunctions and psychological disorders is not fully understood, clinical investigations have recognized the interdependency between the two disorders (7). The association between thyroid function and postpartum mood disorders was seen in Greek women, where lower levels of FT3 and FT4 serum were linked to increased mood disturbances in the first postpartum week (12).

Our aim was to identify signs of interdependency between thyroid dysfunctions before or during pregnancy or after giving birth and postpartum depression measured by the Edinburgh Postnatal Depression Scale (EPDS). However, our data indicate no relationship between thyroid disorder and postpartum depression, as indicated by the Chi Square test.

These results are similar to other research works. Iseme et al. showed no association between depression

and thyroid autoantibodies, based on a group of 2,049 subjects (13). Moreover, treatment with thyroxine administered to thyroid antibody positive women showed no impact on reducing the incidence of postpartum depression (14). Rather, postpartum depression may be more associated with other factors, including psychosocial stressors, previous psychiatric history, complications during pregnancy, or the delivery process itself (15, 16).

The study has limitations, as it was performed on a relatively small group of 61 patients, and the number of patients diagnosed with thyroid disorders was even smaller (seven patients with existing disorders before pregnancy plus one person diagnosed with thyroid disorder during pregnancy). Moreover, patients were predominantly from Bucharest or nearby Ilfov county (65.6 percent of the overall number), the rest being from other counties. The geographic distribution of postpartum depression is fairly similar to the total distribution. In terms of thyroid disorder, of the seven patients diagnosed before pregnancy, four were from Bucharest, one from Ilfov, and two from other counties. The size of the group did not allow identification of endemic regions for thyroid disorders (17-19).

Another limitation of the study could be the retrospective assessment of depression using the EPDS questions. Specifically, patients were asked to evaluate their depression at three months after birth, but the EPDS questions were answered one year after birth. Additional data were not available as to whether patients had received any psychological counselling during or after pregnancy (20, 21).

Conclusions

The relationship between postpartum depression (measured on the EPDS scale, three months after birth) and thyroid dysfunctions (discovered and treated before pregnancy or during pregnancy) was investigated and statistically tested in order to assess any relationship between these variables.

This study found no relationship between postpartum depression and thyroid dysfunction. Thus, thyroid screening during pregnancy may not be useful. Nevertheless, the study shows a percentage of women suffering from postpartum depression (an estimate of 38%), exceeding the 10 to 15 percent reported in other studies. At the same time, postpartum depression is not regularly screened for in Romania. The study identifies the possible need for appropriate and constant assessment of postpartum depression and the establishment of an

appropriate medical structure to identify and mitigate the risks of postpartum depression.

Conflict of interest disclosure

There are no known conflicts of interest in the publication of this article. The manuscript was read and approved by all authors.

Compliance with ethical standards

Any aspect of the work covered in this manuscript has been conducted with the ethical approval of all relevant bodies and that such approvals are acknowledged within the manuscript.

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