

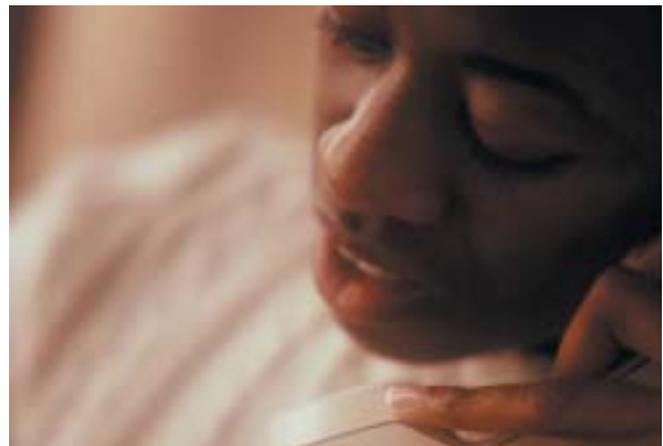
SPECIAL TOPIC: POSTPARTUM MOOD DISORDERS

KEY FACTS

- Seventy to 80 percent of U.S. women who give birth experience postpartum blues (American College of Obstetricians and Gynecologists, 1999).
- Ten to 15 percent of U.S. women have a major depressive episode in the postpartum period (Inwood, 1985; O'Hara, 1987).
- Of every 1,000 women who give birth, between 1 and 2 experience postpartum psychosis (American Psychiatric Association, 1994, 2000; Inwood, 1985; O'Hara, 1987).

After the onset of puberty, females are at higher risk for depression than males (American Psychiatric Association, 1994, 2000). Episodes of depression can affect both individual and family functioning. During the months following the birth of a child, families are vulnerable to the effects of postpartum mood disorders. During the postpartum period, mothers may experience postpartum blues, postpartum depression, or postpartum psychosis.

New mothers often experience a range of intense emotions (e.g., joy, anxiety, sadness) that can be affected by fatigue and by social and family stressors. Postpartum blues are common and are usually self-limited. Recent research indicates that postpartum blues may be physiologically normative (Miller and Rukstalis, 1999). In contrast, postpartum depression is a serious disorder with potentially long-lasting consequences. Distinguishing depression from postpartum blues is therefore critical. Postpartum psychosis is a psychiatric emergency that may manifest itself as one of several different disorders; bipolar mood disorder accounts for the majority of cases.



DESCRIPTION OF SYMPTOMS

Postpartum Blues

(Diagnostic codes: 309.0, adjustment disorder with depressed mood; 309.28, adjustment disorder with mixed anxiety and depressed mood)

- Predominantly positive mood punctuated by labile and intense episodes of tearfulness, irritability, sadness, reactivity to slights, and an exaggerated sense of empathy (Miller and Rukstalis, 1999)
- Begin during first few weeks after delivery (usually in first week, peaking at 3 to 5 days)

- Last from hours to several days
- Resolve without significant consequences
- May be related to hormonal shifts following delivery (progesterone, estrogen, beta-endorphins, cortisol, prolactin, oxytocin, thyroid, and vasopressin are some hormones that have been studied), although evidence is inconsistent and limited as to the exact processes and specific hormones involved

Postpartum Depression

(Diagnostic code: 296.2x or 296.3x)

Adapted from DSM-IV-TR. Selected additional information from DSM-IV-TR is available in the appendix. Refer to DSM-IV/DSM-IV-TR for full psychiatric criteria and further description.

Onset can be insidious, but postpartum depression starts within the first 2–3 months after delivery.

- Five or more of the following symptoms present for at least 2 weeks:
 - Consistently depressed mood
 - Loss of pleasure/interest

- Poor concentration or indecisiveness
- Feelings of worthlessness or guilt
- Recurrent thoughts of death
- Psychomotor agitation or retardation
- Fatigue or loss of energy
- Insomnia or hypersomnia*
- Significant decrease or increase in appetite*

*These symptoms are often difficult to assess in the postpartum period

Postpartum Psychosis

(Diagnostic code: 296.x4, mood disorder with psychotic features; 298.9, psychotic disorder not otherwise specified)

Adapted from DSM-IV-TR and Nonacs and Cohen, 2000. Selected additional information from DSM-IV-TR is available in the appendix. Refer to DSM-IV/DSM-IV-TR for full psychiatric criteria and further description.

Usually starts within 2 to 4 weeks of delivery, but can start as early as 2 to 3 days after delivery. Onset can be dramatic and abrupt. Postpartum psychosis is a psychiatric emergency and requires immediate evaluation.

- Early signs typically include restlessness, irritability, and insomnia
- Typical features include a rapidly evolving or shifting depressed or elated mood
- Behavior may be disorganized, and mother may be confused and disoriented
- Hallucinations or delusions (which frequently focus on the infant) are present

COMMONLY ASSOCIATED PSYCHOSOCIAL PROBLEMS AND MENTAL DISORDERS

- Family stresses
- Domestic violence
- Substance abuse

INTERVENTIONS

Early identification of mothers who are at risk for a postpartum mood disorder enables health professionals to initiate services that could prevent later problems. These interventions can be provided by both obstetric professionals and primary care health professionals working with the family before, during, and after delivery.

Mother

1. During pregnancy (e.g., at the initial/prenatal visit) and the postpartum period, women with the following risk factors should receive close follow-up and support:

- For women with a history of mood disorders (depressive and bipolar disorders) anxiety disorders, or psychotic disorders
 - Women with symptoms of any of these disorders should receive a timely psychiatric evaluation. (Women with suicidal ideation or psychotic symptoms should be evaluated immediately.)
 - Women with significant histories but no current symptoms of these disorders should be monitored for recurrence of symptoms.
- For women with a history of substance abuse
 - Discuss the woman's history of and current alcohol/drug use. (All pregnant women should be asked about alcohol/drug use.)

- Encourage the woman to call her health professional if she feels overwhelmed or at risk for using, or has relapsed.
 - Refer the woman to a treatment program if she is currently using substances.
2. The infant's primary care health professional may be the first person to become aware of emerging depressive symptoms in a new mother. Newborn and infant visits offer invaluable opportunities for primary care health professionals to assess how new parents are adjusting. Assessing the new mother using the following suggestions can help the primary care health professional determine whether the mother is at risk for a postpartum mood disorder:
- Ask the mother if she is feeling overwhelmed, stressed, anxious, or depressed. Ask her how she is feeling physically. How is her energy level? Is she able to rest when her baby is sleeping? Is she eating adequately? Ask how she feels about the baby.
 - Be aware that new mothers may desire to present themselves as doing well during the office visit but may still be struggling to function at home. Look for the following signs of distress in the mother:
 - The mother exhibits sad or angry facial expressions.
 - The mother engages in little baby talk and does not speak much to her infant.
 - The mother is not interactive (e.g., does not play much with or affectionately touch her infant).
 - The mother is intrusive with her infant (e.g., disturbs infant's sleep unnecessarily, tries to feed infant when he is not hungry).
 - The mother appears confused and disoriented or talks about her infant in an inappropriate way.
 - If the mother appears to be experiencing distress, assess her further for postpartum mood disorders. Consider having her complete a questionnaire such as the Kennerley Blues Questionnaire (Kennerley and Gath, 1989) or the Edinburgh Postnatal Depression Scale (Cox et al., 1987) during the visit. (See Tool for Health Professionals: Edinburgh Postnatal Depression Scale [EPDS], *Mental Health Tool Kit*, p. 59.) Ask any mother with significant depressive symptoms for permission to discuss the problem with the mother's own health professional, and offer to initiate referral to a mental health professional.



- Mothers with symptoms of postpartum depression should be asked directly about suicidal ideation or intent. If a mother has suicidal ideation, she should be asked if she has a plan to harm herself. An immediate mental health evaluation is necessary if the mother has a plan, or describes suicidal ideation and also has significant risk factors (e.g., previous suicide attempt, family history of suicide, access to a gun, past or current psychotic disorder, psychotic/delusional thoughts, substance abuse).
- Mothers with symptoms of postpartum depression and/or confusion or agitation should be assessed for symptoms of psychosis: disorientation, hallucinations, and delusional thinking (especially delusional ideas and/or homicidal thoughts about the infant). Suicidal ideation should also be assessed (see above bullet). Ask,
 - “Have you felt confused or unable to think clearly?”
 - “Have you heard voices or seen things that others don’t seem to hear or see?”
 - “Have you had any thoughts about your baby that have worried or frightened you?”
 - “Do others think you have any strange ideas about your baby?”
 - “Have you felt like hurting your baby, your other children, your partner, or yourself?”

Mothers who present with postpartum psychotic symptoms represent a psychiatric emergency and should receive immediate psychiatric evaluation. They usually require psychiatric hospitalization. The infant’s safety needs to be ensured while the mother is being evaluated and treated.

3. By becoming familiar with the spectrum of postpartum mood disorder symptoms, health professionals can consider interventions appropriate to the level of distress.

- Postpartum blues
 - Postpartum blues are usually self-limited and generally respond well to reassurance, increased social supports for the family, and rest for the mother.
 - If symptoms of sadness, tearfulness, or irritability persist for more than 1 week, the mother may be developing postpartum depression.
 - Monitor the mother closely for the development of more persistent depressive symptoms. (See Tool for Health Professionals: Edinburgh Postnatal Depression Scale [EPDS], *Mental Health Tool Kit*, p. 59.)
 - Offer the mother suggestions for how she can take advantage of community and extended family supports.
 - Check in regularly with the mother via office visits or phone calls.
- Postpartum depression
 - Women whose symptoms meet criteria for major depression should be referred for mental health evaluation and treatment. (See Tool for Health Professionals: Edinburgh Postnatal Depression Scale [EPDS], *Mental Health Tool Kit*, p. 59.) Women who were previously reluctant to seek help from a mental health professional may welcome a referral during this vulnerable period, realizing the impact their symptoms may be having on their family.

- Even after making a referral to a mental health professional, the primary care health professional should continue to provide critical support for the mother struggling with depressive symptoms. Following are suggestions for how to provide helpful support:
 - Schedule frequent office visits
 - Check in with the mother frequently, and provide her with an after-hours phone number for questions and concerns.
- Help the mother understand her infant's particular sensitivities and temperament (e.g., affirming that her infant needs extra help to feed may help reduce guilt or self-blame; anticipating the challenges of caring for an infant with special health care needs may help a mother feel supported).
- Ensure that the mother is connected with other health professionals (e.g., visiting nurses, lactation consultants) and needed services (e.g., WIC, Medicaid).
- Help new parents identify sources of support in their community (e.g., friends, relatives, support groups, faith-based organizations).
- Discuss practical issues that may be worrying parents (e.g., when the mother should return to work, how to access appropriate child care or housing).
- Provide information about national and local support networks; for example, Depression after Delivery: (800) 944-4PPD (4773); Maternal and Child Health (MCH) Hotline: (800) 311-BABY (2229), (800) 504-7081 (Spanish); Postpartum Support, International (805) 967-7636.
- Postpartum psychosis
 - As stated in #2 above, mothers who present with postpartum psychotic symptoms represent a psychiatric emergency and should receive immediate psychiatric evaluation. They usually require psychiatric hospitalization. The infant's safety needs to be ensured while the mother is being evaluated and treated.

Infant

1. Postpartum depressive symptoms can affect an infant's well-being in the following ways (Seifer and Dickstein, 2000):
 - Mothers may lack energy to care for their infant or to be responsive to their infant's needs
 - The risk of impaired mother-infant attachment increases
2. Recognizing the following nonverbal signs of distress in an infant may help primary care health professionals recognize maternal difficulties early:
 - Infant looks at mother and others less than most infants
 - Infant vocalizes less than most infants
 - Infant tends not to exhibit positive emotional expressions (e.g., smiling, cooing)
 - Infant lacks interest in objects and exploring
 - Infant exhibits fussy, irritable behaviors
 - Infant exhibits more averting behaviors (e.g., twisting away, arching) than most infants

3. To help foster attachment between mother and infant, highlight the infant's developing social responsiveness and preference for the mother. For example, say "See how she turns when she hears your voice," or "Look at how he smiles when he sees you."
4. Monitor the infant's physical growth, attachment, and self-soothing behaviors. (See the Infancy chapter, pp. 15–48, for more information.)

Family

1. Assessing the following key areas during prenatal and infant visits can help primary care health professionals identify families that may need more support:
 - Are parents able to support each other in caring for their infant and in running the household?
 - Are other family members available for support?
 - How are siblings adjusting to the new infant?
 - Are the family's basic needs (food, shelter, transportation) being met?
2. If concerns about care for the infant and family functioning arise because of the presence of a postpartum mood disorder, obtain permission to contact other individuals (e.g., grandparents, visiting nurses, early intervention specialists) who may be able to help the primary care health professional ascertain how the family is coping with the arrival of the new infant.
3. Identifying the following risk factors early can help the primary care health professional suggest specific interventions before the situation escalates:
 - Strong family history of mood or other psychiatric disorders
 - The primary care health professional should closely monitor the mother for symptoms
 - Relationship problems between the mother and her partner
 - Ask the mother whether the pregnancy or the arrival of the infant has caused any problems between her and her partner, and whether she has felt isolated since becoming pregnant or giving birth.
 - Encourage the mother to engage available supports (e.g., relatives, friends, faith-based community, health professionals, support groups, crisis hotlines).
 - Domestic violence (See also bridge topic: Domestic Violence, p. 227.)
 - If the family is currently experiencing domestic violence, both the mother and the infant and any other children or adolescents in the family need physical and mental health assessments as well as referral to safe shelters or other secure living situations.
 - If there is a history of domestic violence, discuss how the mother can access safe shelters and other services if she needs them. Help couples problem solve about how to deal with specific stressors, and offer referrals to mental health professionals with expertise in domestic violence.
 - Poor social supports or lack of assistance with child care
 - Help parents access all available sources of support (e.g., relatives, friends, and community resources such as support groups, faith-based communities, visiting nurses, social service agencies).

- Adolescent parents
 - Make an extra effort to help the new mother anticipate her own and her family's needs during pregnancy and the postpartum period.
 - Make an extra effort to include the infant's father in prenatal visits, delivery, and child care.
 - While the mother is pregnant, discuss how she will continue or re-enter school after delivery.
 - Help parents use support from family, friends, and community resources, as discussed above. Support from the infant's grandparents is especially important.

Community

1. Ask about who is providing the family with support (e.g., friends, relatives), and help parents access additional sources of support as needed (e.g., visiting nurses, parenting groups, support and social groups for new parents, early intervention services for the infant).
2. Assess how safe the family feels in their living situation, and refer for housing assistance if indicated.

Resources for Families

Depression After Delivery

91 East Somerset Street

Raritan, NJ 08869

Phone: (800) 944-4PPD (4773)

Web site: <http://www.behavenet.com/dadinc>



Maternal and Child Health (MCH) Hotline
 Phone: (800) 311-BABY (2229), (800) 504-7081
 (Spanish)

National Library of Medicine

Web site: <http://www.nlm.nih.gov/medlineplus/postpartumdepression.html>

Postpartum Support, International

927 North Kellogg Avenue

Santa Barbara, CA 93111

Phone: (805) 967-7636

Web site: <http://www.postpartum.net>

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