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Psychiatric disorders in the postpartum period

Postpartum mood disorders and psychoses must be identified to prevent negative long-term consequences for both mothers and infants.

ABSTRACT: Pregnant women and their families expect the postpartum period to be a happy time, characterized by the joyful arrival of a new baby. Unfortunately, women in the postpartum period can be vulnerable to psychiatric disorders such as postpartum blues, depression, and psychosis. Because untreated postpartum psychiatric disorders can have long-term and serious consequences for both the mother and her infant, screening for these disorders must be considered part of standard postpartum care.

The three psychiatric disorders most common after the birth of a baby are postpartum blues, postpartum depression, and postpartum psychosis. Depression and psychosis present risks to both the mother and her infant, making early diagnosis and treatment important. (A full description of pharmacological and nonpharmacological therapies for these disorders will appear in Part 2 of this theme issue in April 2005.)

Postpartum blues

Postpartum blues refers to a transient condition characterized by irritability, anxiety, decreased concentration, insomnia, tearfulness, and mild, often rapid, mood swings from elation to sadness. A large number of postpartum women (30% to 75%) develop these mood changes,[1] generally within 2 to 3 days of delivery. Symptoms peak on the fifth day postpartum and usually resolve within 2 weeks.[2] Typically, providing support and reassurance to the new mother and stressing the importance of adequate time for sleep and rest will be sufficient treatment for postpartum blues. The use of minor tranquilizers at low doses (e.g., lorazepam 0.5 mg) may be helpful for insomnia. Careful monitoring during this period is essential, since a small proportion of women with postpartum blues may develop postpartum depression.[3]

Postpartum depression

The *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* (*DSM-IV-TR*) defines postpartum depression (PPD) as depression that occurs within 4 weeks of childbirth.[4] However, most reports on PPD suggest that it can develop at any point during the first year postpartum, with a peak of incidence within the first 4 months postpartum.[1] The prevalence of depression during the postpartum period has been systematically assessed; controlled studies show that between 10% and 28% of women experience a major depressive episode in the postpartum period, with the majority of studies favoring a 10% figure.[5]

Several key risk factors have been identified as major contributors to the development of PPD, including:

- A history of postpartum depression.[6]
- A history of depression before conception.[7]

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- A family history of depression, particularly PPD.[7,8]

In addition, several other factors may contribute to the development of PPD, including poor social support, the experience of adverse life events during the postpartum period, marital instability, young maternal age, and infants with health problems or perceived "difficult" temperaments.

Symptoms of PPD are similar to the symptoms of a major depressive episode experienced at any other time (see the **Table**). There are, however, subtle differences, including:

- Difficulty sleeping when the baby sleeps.
- Lack of enjoyment in the maternal role.
- Feelings of guilt related to parenting ability.

Table. Criteria for a major depressive episode.

A. Five or more of the following symptoms* must be present daily or almost daily for at least two consecutive weeks:

1. Depressed mood.
2. Loss of interest or pleasure.
3. Significant increases or decreases in appetite.
4. Insomnia or hypersomnia.
5. Psychomotor agitation or retardation.
6. Fatigue or loss of energy.
7. Feelings of worthlessness or guilt.
8. Diminished concentration.
9. Recurrent thoughts of suicide or death.

**At least one of which must be 1 or 2.*

B. The symptoms do not meet the criteria for other psychiatric conditions.

C. The symptoms cause significant impairment in usual functioning at work, school, and in social activities.

D. The symptoms are not caused by the direct effects of a substance or a general medical condition.

E. The symptoms are not better accounted for by the loss of a loved one.

Source: Adapted from *DSM-IV-TR*.[3]

A significant number of women also experience concomitant symptoms of anxiety, including panic attacks and obsessional fears or images of harm occurring to their babies. These can be very frightening for the mother.

Prior to making a psychiatric diagnosis in the postpartum period, it is important to rule out any underlying medical condition. Women suffering from early postpartum anemia may be at increased risk of developing postpartum depression.[9] Likewise, we know that the postpartum period is associated in some women with pathological changes in thyroid function, especially thyroiditis.[10] Testing for CBC and TSH should be part of a complete workup.

Despite the identified symptoms and risk factors associated with the illness, PPD is often missed at the primary care level. One explanation for this is that the care provider may be more focused on the health of the infant and may therefore miss any signs of maternal psychiatric illness. In addition, many women may try to conceal their illness because of shame or embarrassment about feeling depressed during what is supposed to be such a happy time. The consequences of misdiagnosing or not treating postpartum depression can be serious. For the mother, untreated depression can lead to the development of a chronic depressive illness and poses a risk of suicide. Untreated PPD can also have many negative consequences for the infant; the negative interactive patterns formed during the critical early bonding period may affect the later development of the child. For example, conduct disorders, inappropriate aggression, and cognitive and attention deficits have been described in children exposed to maternal psychiatric illnesses and these disturbances have continued even after remission of the maternal depression.

Every new mother should be asked about her psychological functioning. Women with a history of major depression or a family history of psychiatric illness should be identified in pregnancy and followed closely in the postpartum period. A very useful and easily administered screening tool for postpartum depression is the validated Edinburgh Postnatal Depression Scale (see **Figure**; this scale can be copied and used free of charge).[11-13] The patient can complete the questionnaire at her physician's office prior to her first postpartum follow-up appointment or when she brings her baby for immunization. For each question, the patient will choose one of four possible replies that reflect how she has been feeling over the past 7 days. Responses are scored as 0, 1, 2, or 3, for a maximum score of 30. A minimum score of 12 has been found to identify most women with a diagnosis of postpartum depression.

Postpartum psychosis

First-onset psychosis in the perinatal period is a rare condition. The prevalence of postpartum psychosis has consistently been reported as approximately 1 to 2 per 1000 live births.[14] This condition has a rapid onset, usually manifesting itself within the first 2 weeks after childbirth or, at most, within 3 months postpartum, and should be considered a medical and obstetrical emergency.[15] The presence of a psychotic disorder may interfere with a woman obtaining proper prenatal and postpartum care.

Several major risk factors[16-18] have been identified in relation to postpartum psychosis:

- History of psychosis with previous pregnancies.
- History of bipolar disorder.
- Family history of psychotic illness (e.g., schizophrenia or bipolar disorder).

Patients may present with symptoms resembling an acute manic episode or a psychotic depression. They may present with delusions or hallucinations that are frightening to them. Many patients also have additional symptoms that resemble a delirium and involve distractability, labile mood, and transient confusion.[19]

Patients with postpartum psychosis have lost touch with reality and are at risk of harming themselves or their babies. Postpartum psychosis is an emergency that requires immediate medical attention. In most cases, it will be necessary for the mother to be hospitalized until she is stable. Medications (including antidepressants, neuroleptics, and mood stabilizers) or electroconvulsive therapy may be needed to control the psychosis.

The absolute risk of neonaticide (death of the baby within 24 hours of birth) and of infanticide (death within the first year of life) committed by the mother are not known. Both are relatively rare but attract much media attention when they occur. It is imperative to ask all women suffering from a postpartum illness if they have any thoughts or plans of harming themselves or their children. Patients presenting with suicidal or infanticidal plans require emergency hospitalization.

Summary

The postpartum period can be a vulnerable time for women, particularly those with a history of psychiatric illness or a family history of psychiatric illness. Not treating a psychiatric disorder in the postpartum period can have both short- and long-term consequences for both the infant and the mother. Administering a routine screening test, such as the Edinburgh Postnatal Depression Scale, can help identify those mothers who require treatment.[20-23]

Competing interests

None declared.

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Name: _____ **Date:** _____ **Number of months postpartum:** _____

As you have recently had a baby, we would like to know how you are feeling. Please mark the answer which comes closest to how you have felt *in the past 7 days,* not just how you feel today.

Here is an example, already completed:

I have felt happy:

- ☐ Yes, all the time
- ☒ Yes, most of the time
- ☐ No, not very often
- ☐ No, not at all

This would mean "I have felt happy most of the time during the past week." Please complete the following questions in the same way.

In the past 7 days:

1. I have been able to laugh and see the funny side of things
   - ☐ As much as I always could 0
   - ☐ Not quite so much now 1
   - ☐ Definitely not so much now 2
   - ☐ Not at all 3

2. I have looked forward with enjoyment to things
   - ☐ As much as I ever did 0
   - ☐ Rather less than I used to 1
   - ☐ Definitely less than I used to 2
   - ☐ Hardly at all 3

3. I have blamed myself unnecessarily when things went wrong
   - ☐ Yes, most of the time 3
   - ☐ Yes, some of the time 2
   - ☐ Not very often 1
   - ☐ No, never 0

4. I have been anxious or worried for no good reason
   - ☐ No, not at all 0
   - ☐ Hardly ever 1
   - ☐ Yes, sometimes 2
   - ☐ Yes, very often 3

5. I have felt scared or panicky for no very good reason
   - ☐ Yes, quite a lot 3
   - ☐ Yes, sometimes 2
   - ☐ No, not much 1
   - ☐ No, not at all 0

6. Things have been getting on top of me
   - ☐ Yes, most of the time I haven't been able to cope 3
   - ☐ Yes, sometimes I haven't been coping as well as usual 2
   - ☐ No, most of the time I have coped quite well 1
   - ☐ No, I have been coping as well as ever 0

7. I have been so unhappy that I have had difficulty sleeping
   - ☐ Yes, most of the time 3
   - ☐ Yes, sometimes 2
   - ☐ Not very often 1
   - ☐ No, not at all 0

8. I have felt sad or miserable
   - ☐ Yes, most of the time 3
   - ☐ Yes, quite often 2
   - ☐ Not very often 1
   - ☐ No, not at all 0

9. I have been so unhappy that I have been crying
   - ☐ Yes, most of the time 3
   - ☐ Yes, quite often 2
   - ☐ Only occasionally 1
   - ☐ No, never 0

10. The thought of harming myself has occurred to me
    - ☐ Yes, quite often 3
    - ☐ Sometimes 2
    - ☐ Hardly ever 1
    - ☐ Never 0

Figure. Edinburgh Postnatal Depression Scale.[11]