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## Clinical Overview

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**What is postpartum depression? Does it differ from depression that occurs at other times?**

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**How common is it?**

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**What are its symptoms? How do clinicians diagnose it?**

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**Once a woman has experienced postpartum depression, what are her chances of experiencing further episodes of depression?**

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**What other types of mood disorders are common to the postpartum period?**

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Childbirth is a time of great physiological, psychological and social change. Having a psychiatric illness at such a crucial time in family life affects the mother, her partner, her children and family, and as such represents a considerable public health problem.

For centuries, medical professionals have noted the association between childbirth and mental illness. Studies have shown that women are at increased risk of developing a severe mood (or affective) disorder in the postpartum period, and are at a much greater risk of being admitted to a psychiatric hospital in the first month postpartum than at any other time in life (Kendell et al., 1987; Paffenbarger, 1982). Service providers working with new mothers will likely provide care to women who have the illness.

This chapter describes the affective states that are common following childbirth, focusing on **postpartum depression (PPD)**; other disorders described include the baby blues and pinks, postpartum anxiety and **psychosis**. The chapter will differentiate between the disorders, and highlight problems and symptoms that may require intervention.

## Postpartum Depression (PPD)

### WHAT IS PPD?

Clinicians and researchers use the term “postpartum depression,” or “PPD,” to refer to non-psychotic depression that occurs shortly after childbirth.

### DOES IT DIFFER FROM OTHER DEPRESSIONS?

Apart from the fact that it happens soon after childbirth, PPD is clinically no different from a depressive episode that occurs at any other time in a woman’s life. The symptoms are the same as in general depression, and must meet the same criteria for diagnosis. However, not surprisingly, the content of the symptoms of PPD often focuses on motherhood or infant care topics.

### WHAT CAUSES IT?

Although health professionals do not know what causes depression (and therefore PPD), they accept that there is no single cause. Physical, hormonal, social, psychological and emotional factors may all play a part in triggering the illness. This is known as the **biopsychosocial model** of depression, and is accepted by most researchers and clinicians. The factor or group of factors that trigger PPD vary from one individual to the other.

### HOW COMMON IS IT?

PPD is the most common complication of child-bearing. Although the rates given in individual studies vary greatly, a meta-analysis of 59 studies of more than 12,000 women found that PPD affects an average of 13 per cent of women (O’Hara & Swain, 1996).

### WHEN DOES IT START?

The time period used to define “postpartum” varies, from immediately following childbirth to four weeks (according to formal diagnostic classification systems) after childbirth or up to a year, according to some research studies. Symptoms usually begin within the first four weeks postpartum, although they can start up to 12 months afterwards. However, service providers may not detect and treat PPD until much later. Often, questioning will reveal that the symptoms actually began much earlier than the woman had disclosed to a health care provider.

### HOW DO CLINICIANS DIAGNOSE IT?

A physician or licensed **psychologist** makes a formal diagnosis of depression. Professionals use numerous methods to elicit the information needed to make a diagnosis, including standardized clinical interviews. The clinician’s judgment is essential in deciding whether or not an individual’s symptoms meet diagnostic

criteria, in terms of severity or duration of symptoms. The formal classification system used in North America is the American Psychiatric Association (APA) *Diagnostic and Statistical Manual of Mental Disorders, Fourth edition*, or *DSM-IV* (American Psychiatric Association, 1994). (See Figure 1–1 for *DSM-IV* criteria for a major depressive episode.)

To indicate an episode of PPD using *DSM-IV* criteria, the physician or psychologist would indicate that it is an episode of major depressive disorder with the specifier “postpartum onset” (which means that the symptoms occurred within four weeks of the woman’s having given birth).

Individuals must have exhibited *either a depressed mood or a loss of interest or pleasure* in usual activities (called **anhedonia**) continually, for a minimum of two weeks. In addition, they must have experienced other symptoms from a given list of seven, for a minimum of two weeks.

A clinician will diagnose major depression if the individual has a low mood or anhedonia, plus four other symptoms (for a minimum of five symptoms). People with a low mood or anhedonia with fewer than four symptoms will receive a diagnosis of minor or moderate depression.

### **HOW CAN SERVICE PROVIDERS RULE OUT OTHER CAUSES?**

It is imperative that the symptoms displayed a) represent a change from the individual's normal functioning and b) cause impairment in everyday life. Through referral to the family doctor or another physician, as appropriate, providers should rule out other medical conditions that may cause similar symptoms and may be common in the postpartum period (e.g., thyroid dysfunction, diabetes, anemia, autoimmune diseases).

### **HOW LONG DOES IT LAST?**

The length of an episode varies from a number of weeks to a number of months. Some women say it can take up to a year for them to feel back to their normal selves. In a small number of cases, the episode may not remit and the women experience chronic episodes of depression.

### **WILL IT COME BACK AGAIN?**

Experiencing an episode of depression, at any time in life, increases the likelihood of experiencing further episodes. Research suggests that the *minimum* risk of experiencing a non-childbirth-related episode of illness is 25 per cent (Wisner et al., 2001) and the risk of having another postpartum episode may be as high as 40 per cent, with approximately 24 per cent of all recurrences occurring within the first two weeks postpartum (Wisner et al., 2004).

## **Are There Effective Treatments for Depression?**

*Health professionals can effectively treat depression and most women fully recover.* Depending on the nature of the illness, treatments can include medication, psychological therapies, counselling and support groups. The different types of treatment available are discussed in detail in Chapter 5.

For a discussion of who to refer to and how to obtain a formal diagnosis of PPD, please see Chapter 6.

## RELUCTANCE TO DISCLOSE SYMPTOMS

Women may not be willing to admit to experiencing depressive symptoms for a myriad of reasons, which are discussed in Chapter 3. They may hesitate to talk about how they are feeling because they don't recognize that their symptoms are due to a major mental illness, or because they think they are bad mothers because they are not coping. Or they may feel embarrassed, guilty or resentful, worry about being labelled or stigmatized as mentally ill, or worry that others might minimize or dismiss their fears and concerns. Some cultures do not perceive depression following childbirth as a medical problem that requires intervention. As a result, some women would not seek treatment, or their immediate family would deal with the problem (Oates et al., 2004).

A service provider working with new mothers needs to be aware of the different ways in which depressive symptoms may be presented.

Individuals differ in the *types* of symptoms they experience, the *degree* to which they are affected, and the *manner* and *degree* to which they may disclose symptoms.

Depressive episodes range in severity: some individuals have mild cases through to extremely severe episodes. Irrespective of meeting formal criteria for depression, any woman requires help if she has symptoms that cause her distress, cause problems in her daily living or could become worse.

## Different Clinical Presentations of Depressive Symptoms

### DEPRESSED MOOD

Women often do not admit to being depressed. They may use other words to convey being depressed, such as despondent, low, sad, irritable, restless, numb or empty. The woman may be tearful or cry more than usual, or say that she is past the stage of crying because she is so empty. Often women express strong feelings of inadequacy, particularly regarding their abilities as a mother, and talk about their inability to cope or fear of being labelled as "a bad mother." They may compare themselves with other new moms or female relatives, which increases their feelings of inadequacy.

In some cases, a woman will not disclose that she has psychological problems but will instead focus on physical symptoms. The mother may complain to her doctor or public health nurse of stomach ache, headache or backache. Some women simply cannot disclose their psychological state, and find that focusing on physical symptoms is a more comfortable means of conveying their distress. Other women will focus on the health of the baby, making repeated visits to the doctor's or nurse's office with physical concerns, even if the doctor or nurse has said that the baby is fine.

### **Depression with anxiety**

It is very common for women experiencing PPD to also exhibit anxiety. Within the context of a PPD, the mother may experience anxiety about the baby's health or her own ability as a mother or concern over how she will cope with childcare responsibilities.

While anxiety is a common feature of depression, some individuals exhibit *only* anxiety. That is, they experience anxious feelings but *do not* have depressed mood or loss of interest or pleasure. (Please see discussion of postpartum anxiety on page 11.)

### **ANHEDONIA**

Women with PPD may lose interest or no longer enjoy activities that used to give them pleasure, such as being with the baby, watching a favourite television program, reading or spending time with a partner, family or friends.

### **WEIGHT CHANGES AND APPETITE**

Health professionals usually define the symptom of weight change as a significant weight gain or loss (in the absence of actively dieting). However, this can be hard to assess in new moms whose weight will change after having a baby. Service providers may prefer to inquire about women's *desire* for and *enjoyment* of food; for example, do they still want food (even if they don't have time to prepare something), do they enjoy it and still like their favourite items?

### **SLEEP DISTURBANCE**

Sleep disturbance is a common symptom of depression. However, this is extremely difficult to gauge in new moms. Service providers may prefer to ask about a mom's ability to sleep or get rest when she has the opportunity—for example, can she sleep when the baby falls asleep; or if someone else is watching the baby, can she sleep, nap or rest? Does she have difficulty falling asleep? Does she wake in the middle of the night and can she fall back to sleep? Does she have difficulty waking up in the morning and does she feel refreshed after sleep?

### **FATIGUE**

It is hard to estimate the real extent of tiredness in new moms. The fatigue associated with depression is a *prevailing* sense of exhaustion *irrespective* of the amount of sleep or rest obtained.

### **PSYCHOMOTOR RETARDATION OR AGITATION**

Psychomotor retardation refers to physical feelings of being slowed down, moving slowly or experiencing sluggishness. Psychomotor agitation refers to feelings of being

restless, jumpy and on edge. As well as the mother feeling like this, other people will likely have noticed the movements too, and may have commented on them.

### EXCESSIVE FEELINGS OF GUILT OR WORTHLESSNESS

Some individuals have excessive and inappropriate feelings of guilt or worthlessness. This does not just relate to being ill, but is much more severe. They may negatively interpret everyday activities as confirming their low sense of worth; for example, “The other mothers don’t talk to me because I don’t deserve to have friends because I’m such a bad person.” These women may feel guilt to delusional proportions; for example, some women may feel that they are responsible for world poverty or something bad happening to someone else.

### DIMINISHED CONCENTRATION, INABILITY TO “THINK STRAIGHT”

Clinicians variously describe lack of concentration as slowed thinking, inability to concentrate on the task at hand, being unable to finish a job or having trouble making simple decisions. Some women complain that they “can’t think straight” when confronted by the simplest of tasks.

### RECURRENT THOUGHTS OF DEATH OR SUICIDE

Thoughts of death or suicide are a common feature of depressive illness. In many cases, these thoughts express not simply a fear of dying but a preoccupation with death. Women may not explicitly use words such as suicide, death or killing. But they may say things like “The baby and I would be better off dead,” or “The world is such an awful place to bring a baby into that we would be better off out of it.” Some women feel that they can no longer go on, but cannot bear the thought of leaving the baby behind so would take the baby with them.

Some women have thoughts about hurting the baby that make them feel deeply frightened or ashamed—even though the vast majority would never act on these thoughts. For instance, they might imagine how easy it would be to smother or drown the baby, or throw him or her out of the window. In other cases, women feel it would be a blessing if they went to sleep and didn’t wake up, but would not actively do anything to hurt themselves. Some women are obsessed with such thoughts, but most would never act on them. (See Chapter 6.)

Although highly publicized, acts of **infanticide** and suicide are rare in postnatal illness. Infanticide is estimated to occur in one to three in 50,000 births (Brockington & Cox-Roper, 1988; Jason et al., 1983). Health professionals estimate that 62 per cent of mothers who commit infanticide also go on to commit suicide (Gibson, 1982).

Suicide is a risk factor in depressive illness that must be considered. Chapter 6 further discusses assessing risk of suicide.

## Other Types of Postpartum Mood Disturbance

In this section we will describe other mood disorders that can occur following childbirth.

Postpartum **affective disorders** generally involve three categories: the blues (baby blues, maternity blues), PPD, and **puerperal**, or postpartum, psychosis, each having different symptoms and severity and requiring different management (see Table 1-1). This section also discusses anxiety following childbirth.

TABLE 1-1

### Common Postpartum Mood Disturbances: Summary of Onset, Duration & Treatment

Condition	Prevalence	Onset Often During	Duration	Treatment
<b>Blues</b>	30-75%	Day 3 or 4	Hours to days	No treatment needed other than reassurance
<b>Postpartum Depression</b>	10-15%	Within weeks to 12 months	Weeks to months	Treatment generally required
<b>Puerperal Psychosis</b>	0.1-0.2 %	Within 2 weeks, usually first week	Weeks to months	Hospitalization usually required

Table adapted with permission from Nonacs & Cohen, 1998.

### POSTPARTUM, OR “BABY,” BLUES

Postpartum blues are the most common perinatal mood disturbance, affecting an estimated 30 to 75 per cent of women. The blues tend to appear in the first few hours to days after birth, usually peaking on day three or four. The symptoms only last a few days and generally cease within a week. Typically, the blues appear in a woman who is happy but experiences increased “emotional” responses to stimuli. She may change rapidly from being happy to tearful, and have inexplicable spells of irritability, weepiness, anxiety and sleep and appetite disturbances. Researchers have suggested that some of these effects may result from the rapid hormonal changes occurring.

The blues are mild, generally requiring no treatment other than support and reassurance. By definition, blues do not last longer than two weeks. And while most women remain well thereafter, up to 20 per cent of women with the blues develop major depression within the first year of having a baby. In some cases, women’s symptoms worsen and become depression, while others can recover from the blues and then subsequently experience depression.



## POSTPARTUM PINKS

While “the blues” refers to mood lability (or changes in mood from happy to sad), some women experience mild elation, or “the pinks,” following childbirth; again, this elation lasts for a few hours to days until a more normal level of happiness returns (Glover et al., 1994). Similar to the baby blues, the pinks do not require treatment, and others may not notice the pinks if they view mild elation as a “normal” reaction to childbirth.

*In some situations, symptoms of the blues or pinks require clinical attention. One of the core features of both the blues and pinks is that the mood changes are mild and transient. Extremes of either the blues or pinks are definitely a cause for concern—prolonged mood changes (longer than a few days) or big mood swings from high to low are indications of a more serious mood disorder developing and will require follow-up (see Chapter 6).*

## POSTPARTUM ANXIETY

As for depression, anxiety occurring around pregnancy or following the birth of a child is *clinically* no different from anxiety that occurs at any other time. However, research data on postpartum anxiety is limited compared with data on other postpartum disorders. Studies indicate that between four and 15 per cent of women experience anxiety following childbirth (Wenzel et al., 2003; Matthey et al., 2003; Heron et al., 2004).

Some women experience anxiety only during pregnancy, some only following childbirth, and others throughout pregnancy and the postpartum period. In a recent large study of 8,323 pregnant British women, Heron et al. (2004) found that 7.3 per cent of women reported high levels of anxiety during pregnancy, as measured by a self-report questionnaire. Of those women who had high levels of anxiety during pregnancy, 1.4 per cent also scored high levels of anxiety when measured at eight weeks postpartum. Of the women who did not report high levels of anxiety during pregnancy, 2.4 per cent reported high levels of anxiety postpartum.

Many mothers feel anxious, overwhelmed and scared following the birth of their baby. This is understandable given the changes involved in becoming a new parent. However, for some women the level of anxiety is so severe that it interferes with their daily lives, and represents a change in normal character and functioning.

## DIAGNOSIS

The formal classification of anxiety disorders in the *DSM-IV* covers a range of disorders that may be specific in nature; that is, a specific phobia (such as fear of heights or spiders), panic disorder or obsessive-compulsive disorder. For some people, no one source or situation causes the anxiety, so clinicians consider their condition to be generalized anxiety.

For some women with postpartum anxiety, the fear or anxiety is general, but for others the symptoms may relate to something more specific (i.e., bathing the baby, taking the baby out in the car, coping with grocery shopping) or the symptoms may focus solely on the child (i.e., is the baby feeding properly and breathing properly, is the woman competent as a mother and able to look after the baby?). The mother's anxiety typically exhibits itself as constant and/or excessive worry, fear or apprehension. She may appear edgy, tense and perpetually keyed up. In some cases, women will avoid certain situations because the fear is so overwhelming.

People with anxiety often describe physical symptoms or panic attacks that accompany the anxiety feelings, including:

- sweating
- palpitations
- nausea
- faintness
- an overwhelming urge to run away.

Women with anxiety problems do not experience the persistently low mood and anhedonia (loss of pleasure) that typifies depression, although as previously stated, mothers with PPD may also feel anxious.

## PUERPERAL, OR POSTPARTUM, PSYCHOSIS

In contrast to the blues and PPD, postpartum (or puerperal) psychosis is the most severe and rare form of postpartum mood disorder, with rates of one to two episodes per 1,000 deliveries. The onset of symptoms is rapid, in many cases within 48 to 72 hours after birth, and most cases develop within the first two weeks postpartum. Studies (e.g., Jones & Craddock, 2001) suggest that postpartum psychosis has a genetic or biological cause and is more common in women diagnosed with bipolar disorder or with a family history of mood disorders.

The most common symptoms are extreme depressed or elated mood (mania), similar to that seen in bipolar disorder (or manic depression). Women with puerperal psychosis often fluctuate rapidly between mania and depression, or may experience a "high" (mania) followed by a depression. Women often exhibit bizarre or disorganized behaviour, and are often confused or perplexed.

Most women with postpartum psychosis experience psychotic symptoms. Clinicians define **delusions** as false fixed beliefs that have no rational basis in reality and that the individual's culture deems unacceptable. Common types of delusions involve persecution, love and guilt, for example. Clinicians define **hallucinations** as *perceptual distortions* that have no external stimulus. The most common hallucinations are auditory (hearing noises or voices that nobody else hears) or visual (seeing things that are not present and that other people cannot see) (Dubovsky & Buzan, 1999). Examples of psychotic symptoms include the mother believing that she or her baby has special powers or superior intelligence (e.g., the mother believes that she will write a best-selling book or that she is a famous artist, the mother thinks that she and her baby could be on television because they are so talented). Some women may hear voices telling them to do things or saying things to them (which may be positive or negative).

As previously stated, cases of infanticide and suicide are rare but are a serious risk in women with postpartum psychosis. The symptoms of postpartum psychosis fluctuate rapidly, and a woman who was lucid and calm upon first interview can be suicidal and psychotic within a matter of hours.

The nature of the psychosis is very unpredictable and even an experienced **psychiatrist** can have difficulty detecting it (see Spinelli, 2004). Any woman exhibiting extreme mood changes (high to low) or psychotic symptoms requires an immediate emergency psychiatric referral (see Chapter 6).

## Summary

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PPD is a depressive episode that occurs in the first year postpartum.

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Clinically, PPD is no different from depressions occurring at other times, except the symptoms may be related to the birth or baby.

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PPD is the most common postpartum mood disorder. It affects approximately 13 per cent of new mothers.

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A physician or licensed psychologist makes diagnoses according to *DSM-IV* criteria.

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Symptoms of PPD are, predominantly, feelings of sadness and inability to feel pleasure, in addition to sleep disturbance, fatigue, weight change, physical agitation or retardation, excessive feelings of worthlessness or guilt, decreased ability to concentrate and recurrent thoughts of death or suicide.

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After having PPD, a woman is at risk of experiencing further depressive episodes related to childbirth, and is also at risk of depression at other times.

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Postpartum blues are extremely common in the postpartum period but only last for a few days, and the mood symptoms are mild and transient. PPD is persistent and more severe, lasting a minimum of two weeks and impairing daily functioning.

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Women who experience severe elation and depression, or exhibit any psychotic features (postpartum psychosis), require immediate medical and/or psychiatric referral and probably hospital admission.

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