



Postpartum Conditions: The Blues, Depression and Psychosis

Postpartum Blues:^{1,2}

Occurs: In 50-80 percent of women

Onset: Day 3 to day 14 post partum

Symptom Duration: Persists several days to few weeks

Rx: Spontaneously remits³

Symptoms

- Mood instability/irritability
- Weepiness
- Sadness/feeling vulnerable
- Lack of confidence/overwhelmed
- Anxiety/nervousness
- Poor concentration
- Difficulty sleeping
- Loss of appetite

What complicates the diagnosis?:³

- New mothers often think it takes time to adjust and so think their depression is normal.
- Stigma plays a major role. (Less than 20 percent reported their symptoms to a caregiver – only 33 percent believed they had a postpartum depression – Whitton, et al 1996).
- Societal pressure creates a sense of shame or guilt in the mother who says “something’s wrong.”
- Fear that the physician might declare the mother “unfit” and try to take away the child.
- Mother fears that she is crazy or will become psychotic.
- Mother’s confusion on where to turn (the pediatrician, the Ob/Gyn).
- Physicians who try to be supportive delay the diagnosis and treatment.
- Physicians who spend too little time with the mother exploring the emotional impact of the birth.
- Similarities between the normal issues of childbirth and symptoms of depression.
- Depression often seen as “normal” response, stress reaction to childbirth.

Postpartum Depression:³

Occurs: In 8-15 percent of women

Onset: >3weeks post partum; 50 percent by 3 months; 75 percent by 6 months

Symptom Duration: May last from 3 to 14 months, most recover within 1 year; 30 percent have a recurrence

Rx: Early recognition of the symptoms and the risk factors outlined below³

Symptoms:

- Depressed mood, tearfulness, despondency
- Lack of pleasure/interest
- Sleep disturbance (insomnia or hypersomnia)*
- Weight loss, loss of appetite*
- Loss of energy*
- Psychomotor agitation or retardation*
- Mood instability/irritability; inability to cope
- Increased feelings of vulnerability
- Lack of confidence/feeling overwhelmed
- Anxiety/nervousness

- Poor concentration/indecisiveness memory problems*
- Frequent thoughts of death/suicide
- Difficulties with family, infant, husband
- Marked fear of criticism of mothering skills

*Symptoms that are frequently considered normal sequelae of childbirth

Risk factors: ⁴

- Past history of psychopathology and psychological disturbance during pregnancy (50-80 percent if previous post partum depression)
- Low social support
- Poor marital relationship, single parenthood, irritable infant
- Recent life events
- Post Partum Blues sometimes referred to as “Baby Blues”
- Depression/anxiety during pregnancy
- Presence of antithyroid antibodies
- History of abuse, (childhood abuse or domestic violence)
- Baby with a disability, serious illness or extreme prematurity
- Low family income

Other factors: ⁴

- Parent’s perception of her own upbringing
- Unplanned pregnancy
- Unemployment
- Not breast feeding
- Poor coping style
- Longer time to conception
- Depression in fathers
- Having two or more children

Postpartum Psychosis: ^{3,4,5,6,7}

Occurs: In 0.2 percent of women

Onset: First six weeks postpartum (3 to 20 days is the highest risk period)

Symptom Duration: Lasts a few days to a month. 80 percent recover in one year (30 to 50 percent recurrence – high incidence of future affective diagnosis) ⁴

Symptoms:

- Hyperactivity/mood instability
- Increased rate of speech
- Delusions (infant death, denial of birth, need to kill the baby)
- Paranoia
- Extreme confusion
- Hallucinations
- Extreme depression
- Suicidal or homicidal feelings
- Fatigue
- Tearfulness

Risk Factors:

- Previous history of affective disorder (especially psychosis or bipolar disorder)
- Family history of affective disorder
- Previous postpartum psychosis
- First pregnancy
- C-section
- Perinatal death; advanced maternal age; difficult labor

Particular Hazards:

- Signs and symptoms often change rapidly
- Patients are impulsive
- Potential for violence to self or others (5 percent suicide; 4 percent infanticide rate)
- Temporary improvements can be misinterpreted as real remission

Treatment Do's and Don'ts:

Professionals who specialize in the treatment of pre and postpartum depression, suggest the following:⁹

- Do not assume that if she looks good she is fine
- Do not tell her that it's normal to feel this way after a baby
- Do not assume that she will get better on her own
- Do encourage her to get a comprehensive evaluation
- Do take her concerns seriously
- Do let her know that you are there if she needs you

A Patient's History: Professionals who specialize in the treatment of pre and postpartum depression, suggest the importance of knowing the following information about your patient.⁹

- Do you have a history of depression?
- Are you worried about how you feel now?
- Are you sleeping ok when the baby sleeps?
- Do you feel you could lose control?
- Has your appetite changed?
- Do you worry that you are a bad mother?
- Are you feeling particularly anxious?
- Do you find it hard to make decisions?
- Are you frightened to be alone with the baby?
- Does your husband know how you feel?
- Do you feel more irritable than normal?
- Is there anything else you find it hard to talk about?

Any reference in this material to other organizations or companies, including their Internet Web sites, is not an endorsement or warranty of services, information or products provided by those organizations or companies.

This information has been provided to you by CIGNA Behavioral Health. It was collaboratively created by CIGNA Behavioral Health and CIGNA HealthCare and published originally as part of the CIGNA HealthCare Healthy Babies program. Nothing in this information should be construed as a specific recommendation for medical care or treatment. The information in this document is not intended to be a substitute for your professional judgment or experience, but is designed to provide you with additional tools and information that support your efforts and make it easier for you to deliver quality care.

"CIGNA HealthCare" refers to various operating subsidiaries of CIGNA Corporation. Products and services are provided by these subsidiaries and not by CIGNA Corporation. These subsidiaries include Connecticut General Life Insurance Company, Tel-Drug, Inc. and its affiliates, CIGNA Behavioral Health, Inc., Intracorp, and HMO or service company subsidiaries of CIGNA Health Corporation and CIGNA Dental Health, Inc.

¹ Pitt, B., "Maternity Blues"; *British Journal of Psychiatry* 1973; 122: 431-433.

² Whiffen, V.E., Gotlib, I.H., Infants of postpartum depressed mother, *Infant Behavioral Development* 1984; 7: 517 - 522.

³ Nonacs, R.M., *e-Medicine*, Post Partum Depression Last Update: August 8, 2004.

⁴ *Scottish Intercollegiate Guidelines Network*. June 2002.

⁵ O'Hara, M.W., Zekoski, E.M., Phillips, L.H., Wright, E.J., Controlled prospective study of postpartum mood disorders; comparison of childbearing and non-child bearing women.

⁶ American Psychiatric Association, *Diagnostic and Statistical Manual IV-TR*, Washington, D.C., 2000; pp. 422-423.

⁷ O'Hara, M.W., Swain, A.M., Rates and risk of postnatal depression – a meta analysis, *International Review of Psychiatry* 1996; 274: 740-743.

⁸ Kendall, R.E., Chalmers, J.C., Platz, C., Epidemiology of puerperal psychoses, *British Journal of Psychiatry* 1987; 150: 662-673.

⁹ <http://www.postpartumstress.com/ppd-screening-and-tips.html>.