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Postpartum depression:

Beyond the "baby blues"

By screening all pregnant and postpartum women for mood and anxiety disorders, we can promptly identify PPD—a significant health problem that threatens the safety of mothers and their families.

By Michele M. McKelvey, PhD, RN, and Jill Espelin, DNP, APRN, CNE, PMHNP-BC

Postpartum depression (PPD) is a serious perinatal complication and a common concern for many mothers. The World Health Organization reported that in developing countries, approximately 19.8% of pregnant women develop depression following childbirth. According to the CDC, about one in every nine women experience depression after childbirth. The ramifications of PPD are widespread and significantly affect the health of mothers and families. Although the focus of this article is on PPD, it's important to be aware that PPD represents only one aspect of perinatal mood disorders. Depression and anxiety can begin during pregnancy and may take place at any time within the first year after childbirth.

In this article, we present information about postpartum mood disorders, with a focus on PPD, including risk factors, possible causes, signs and symptoms, complications, screening, treatment, and nursing care.

Types of postpartum mood disorders

Women may experience many types of psychiatric problems after childbirth. The American Psychiatric Association's (APA) *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* added a peripartum onset to the psychiatric mood disorder category. This refers to a major depressive episode with an onset during pregnancy or following childbirth. The APA proposes that postpartum psychiatric disorders be considered as one condition with three subclasses: adjustment reaction with depressed mood, postpartum major mood episodes, and postpartum mood episodes with psychotic features.

Adjustment reaction with depressed mood

Adjustment reaction with depressed mood is the mildest manifestation of postpartum mood disorder. This transient mood disturbance is commonly referred to as "postpartum blues" or "baby blues." Recent studies show that approximately 50% to 85% of all mothers experience postpartum blues. First-time mothers can experience more severe postpartum blues because they may have unrealistic expectations of themselves as mothers. This commonly develops between 2 and 4 days after birth, and typically resolves within 14 days.

Mothers experience an emotional letdown after childbirth, as well as physical

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discomfort, fatigue, and uncertainty about their maternal role. Mothers commonly feel overwhelmed, anxious, fatigued, sensitive, and irritable. Although postpartum blues is categorized as adjustment reaction with depressed mood, it frequently occurs in new mothers and doesn't require medical treatment. Assistance with self and infant care, family support, peer support, rest, and healthy nutrition usually enables mothers to recover from postpartum blues.

Although the vast majority of postpartum blues cases resolve within approximately 2 weeks, some women go on to develop PPD. If women continue to experience postpartum blues beyond 2 weeks, they should seek medical attention and be evaluated for a more severe postpartum mood disorder.

Postpartum major mood episodes

Postpartum major mood episodes are also known as PPD, which consists of clinical depression occurring within the first year of childbirth. Mothers are most vulnerable to PPD at approximately the fourth week after childbirth, just before the return of their menses, and at the time of weaning their infants from breastfeeding.

Postpartum mood episodes with psychotic features

Commonly referred to as postpartum psychosis, this is the most serious postpartum mood disorder. Although it remains rare—affecting approximately 1 to 2 in every 1,000 mothers—this disorder has gained a great deal of media attention. In 2001, while suffering from postpartum psychosis, Andrea Yates tragically drowned her five children in a bathtub. This well-known tragedy illustrates the depth of postpartum psychosis and the urgent need for early identification and referral.

Postpartum psychiatric disorder subclasses *cheat sheet*

- Adjustment reaction with depressed mood
- Postpartum major mood episodes (also known as PPD)
- Postpartum mood episodes with psychotic features

Postpartum psychosis is a medical emergency, with risk of suicide and infanticide.

Major risk factors include a history of PPD, postpartum psychosis, depression, or bipolar disorder, as well as a family history of these disorders. Clinical symptoms progress rapidly and include inability to sleep; depersonalization; confusion; disorganized thinking; hallucinations; delusions; and psychomotor disturbances, such as stupor, agitation, and incoherent speech. These clinical features appear within the first few days after childbirth.

Women with postpartum psychosis need referrals for immediate psychiatric care. Treatment of postpartum psychosis is aimed at the specific symptoms of each patient. Treatment may consist of antidepressants, antipsychotics, mood stabilizers, and possibly electroconvulsive therapy (ECT), along with psychotherapy. Infants may need to be removed from their mothers' care to maintain safety. If mothers are breastfeeding their infants, medication risks must be considered. Parents need to consider the risks and benefits of treatment while maintaining the safety of their entire family.

Risk factors

According to the APA, women with a personal or family history of PPD, depression, anxiety, or bipolar disorder are particularly at risk for PPD. Other risk factors for PPD include:

- stressful life events
- financial, employment, or environmental stress
- infertility or complicated childbirth
- difficulty breastfeeding
- loss of a loved one
- burden of caring for a newborn
- social isolation
- adolescent or older mothers.

Possible causes

Although there's no one particular cause of PPD, both emotional and physical factors play a part in this disorder. A

combination of these factors likely contributes to the onset of PPD.

Women who have negative thoughts about themselves as mothers are more likely to develop PPD. And some mothers place unrealistic expectations on themselves to be perfect. New mothers often lack personal time; they may feel unattractive and struggle to find their own identity. These overwhelming feelings can cause mothers to become sleep deprived. With an inadequate amount of sleep or poor sleep, new mothers may have difficulty coping with even simple problems. They may feel like they've lost control of their lives and ultimately question their ability to care for their newborns.

Drops in the following hormone levels may also contribute to depressive episodes:
- estrogen (decreases serotonin and may mimic signs of depression)
- progesterone (may cause anxiety and poor sleep)
- thyroid (may cause lethargy and fatigue).

Signs and symptoms

According to the National Institute of Mental Health, signs and symptoms of PPD include:
- hopelessness, sadness, and mood swings
- irritability, anger, and feelings of being overwhelmed
- isolation
- sleep impairment
- poor appetite
- inability to concentrate or make decisions
- loss of interest in pleasurable activities
- disinterest in caring for the baby
- difficulty maintaining relationships
- physical pain and muscle aches.

Mothers experiencing PPD frequently question their ability to care for their babies. In extreme circumstances, they can have thoughts of harming themselves and/or their babies.

Complications

If mothers with PPD don't receive treatment, they may develop chronic depression, according to the Mayo Clinic. Mothers may have difficulty bonding with their infants. These newborns are at risk for excessive crying, poor nutrition, deficient sleep, developmental delays, and failure to thrive. Untreated PPD can also result in suicide, infanticide, and physical harm to newborns.

Children of mothers with PPD are more likely to have attention-deficit hyperactivity disorder, emotional problems, behavioral problems, and language delays.

Fathers/partners also face an emotional strain from PPD. Although they don't experience the perinatal hormone changes, they're exposed to the demands of becoming a new parent. Partners of women with PPD may become overwhelmed with the practical burdens of caring for their newborns and families. It can also be difficult to witness their partner experiencing PPD; the couple's relationship will likely be strained. It may be especially difficult to integrate a newborn into the family if the father/partner subsequently experiences depression and/or anxiety. Older siblings may also be negatively affected by PPD and at risk for depression and anxiety.

According to the literature, mothers with female partners may be more at risk for PPD. Lesbian mothers may face heterosexist attitudes and homophobia from healthcare providers. Confronting stigma and even rejection from their own families places these mothers at an increased risk for PPD.

Signs and symptoms of PPD

cheat sheet

- Hopelessness, sadness, and mood swings
- Irritability, anger, and feelings of being overwhelmed
- Isolation
- Sleep impairment
- Poor appetite
- Inability to concentrate or make decisions
- Loss of interest in pleasurable activities
- Disinterest in caring for the baby
- Difficulty maintaining relationships
- Physical pain and muscle aches

Screening

The Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN), American College of Obstetricians and Gynecologists, and the American Academy of Pediatrics recommend that all pregnant and postpartum women be screened for mood and anxiety disorders. The AWHONN recommends that all healthcare institutions caring for obstetric, neonatal, and pediatric patients utilize screening for perinatal mood and anxiety disorders.

Postpartum Support International recommends universal screening of all mothers for prenatal depression and postpartum mood and anxiety disorders using evidence-based measurements at the following intervals:

- first prenatal visit
- at least once during the second trimester
- at least once during the third trimester
- first postpartum visit
- 6 months after delivery with the primary care provider
- 12 months after delivery with the primary care provider.

It's also recommended that women are screened in the pediatric setting at the 3-month, 6-month, and 9-month appointments. This comprehensive and collaborative screening approach between obstetric and pediatric providers increases the likelihood of identifying postpartum mood and anxiety disorders, particularly PPD.

Both the Edinburgh Postnatal Depression Scale (EPDS) and the Patient Health Questionnaire (PHQ-9) are validated for use with pregnant and postpartum women. These are brief, self-administered questionnaires that assess for depressive symptoms, as well as suicidal ideation. The EPDS also addresses anxiety.

The Postpartum Depression Screening Scale (PDSS) is also a useful, valid, evidence-based screening instrument to detect PPD. The PDSS is a self-administered questionnaire that screens women for PPD and evaluates the presence of suicidal ideation.

Nurses should continuously assess for decline or stability in maternal mood during the first 24 to 48 hours after birth. If mothers show signs of declining mood, nurses should refer them for immediate evaluation and treatment of PPD. All postpartum patients may benefit from referrals to lactation consultants, breastfeeding support groups, and new mother peer support groups.

Treatment

The most effective treatment for PPD is a combination of antidepressants and mood stabilizers with psychotherapy (including individual therapy, group therapy, and/or family therapy). This combination is usually associated with positive results in women with mild-to-moderate PPD. Women diagnosed with PPD typically continue taking antidepressants for a year after their symptoms subside.

Antidepressants may take up to 6 weeks to alleviate symptoms of depression. Because ECT is often effective within 1 week, it may be used for mothers with severe PPD, those who don't respond to medications, or those who are at high risk for suicide.

Selective serotonin reuptake inhibitors (SSRIs), such as sertraline, are commonly used to treat PPD, as well as mood stabilizers such as valproate. When SSRIs aren't effective, tricyclic antidepressants, such as amitriptyline, may be used. These medications may transfer into the mother's breast milk. The FDA recommendation is to either stop the medication or stop breastfeeding. Mothers may consider feeding alternatives, such as formula or the use of donated breast milk.

Pharmacologic treatment for mothers who are breastfeeding must be carefully

key points

Mothers typically go to their first postpartum follow-up visit at 6 weeks after delivery. If the mother is at risk for PPD, this follow-up appointment should be scheduled sooner, ideally at 2 to 3 weeks after delivery. During this visit, the mother should be formally evaluated for PPD. Although PPD may develop within a year of childbirth, there's an elevated risk at approximately 4 weeks' postpartum. Planning for an earlier postpartum follow-up visit enables nurses to identify women with PPD sooner and promptly refer them for appropriate care.

considered. Although some of the antidepressant medication is excreted into breast milk, most SSRIs and mood stabilizers are considered safe for breastfeeding but need to be closely monitored. If the baby shows signs of irritability, sedation, feeding difficulty, or sleep disturbance, the medication may need to be discontinued. Mothers should communicate with their healthcare providers to choose the best treatment for themselves and their families. The potential benefits and risks of treatments must be carefully considered. Other modalities, such as yoga, exercise, meditation, and relaxation, can also be encouraged to enhance psychological and physical well-being.

Psychotherapy may be used alone or in combination with medication. There are several psychotherapy approaches that may be employed, such as interpersonal therapy or talk therapy. Both types allow the mother to speak openly about personal feelings and concerns with a qualified individual, such as a psychologist, social worker, or advanced practice RN, who's nonjudgmental and neutral. The therapist and mother identify specific problems, plan goals, and work to accomplish these goals. The mother also gains new skills in problem solving.

Nursing care

The following case study will utilize the nursing process to provide therapeutic, evidence-based, family-centered care for a patient with PPD.

Maria is a 39-year-old woman who gave birth to her first baby daughter 6 weeks ago after a long history of infertility treatment and two miscarriages. She's having difficulty breastfeeding and her baby wakes up hourly throughout the night to feed. Even when the baby is asleep, Maria says that she can't rest and she feels exhausted. She has a poor appetite and feels sad most of the time.

Maria's husband is supportive, but he works two jobs to pay for medical expenses from their fertility treatments. She's alone most of the time and feels overwhelmed.

Maria's pregnancy and labor/delivery were physically uneventful. She worried about possibly having another miscarriage and describes being very sad during the pregnancy because of the loss of her first two babies. Maria states that she loves her baby, but she just doesn't feel like a good mother. Maria comes to the postpartum clinic for her routine follow-up appointment.

Assessment

First, complete a thorough health history and identify any risk factors for PPD. Ideally, this should begin at the first prenatal visit and continue throughout all prenatal care visits. Ask Maria open-ended questions and use active listening to determine if she's at risk for PPD. Use a nonjudgmental approach because Maria may be embarrassed to admit her feelings of sadness.

Motherhood and pregnancy are generally expected to be happy occasions; be aware that there may be a stigma associated with PPD. Mothers with PPD may avoid seeking help and obtaining treatment because they fear judgment and being labeled as an inadequate mother. For this reason, PPD is underreported. Mothers with PPD often experience shame over their depressive symptoms. They may be reluctant to reveal that they're unhappy after the birth of their babies. That's why all mothers must be formally screened for PPD with a reliable, valid instrument, such as the EPDS, PHQ-9, or PDSS.

Maria presents with many risk factors for PPD, including:

- history of depression and anxiety
- past miscarriages and infertility treatment
- financial stress
- social isolation
- poor sleep and appetite
- difficulty breastfeeding
- older first-time mother.

If Maria admits to thoughts of wanting to hurt herself or the baby, it's critical to conduct a thorough risk assessment, including:

- suicidal or homicidal ideation (thoughts of harming self or baby)

did you know?

Prolactin levels remain elevated in breastfeeding women throughout the course of lactation. Prolactin can have a relaxing, calming effect on lactating mothers. Evidence suggests that breastfeeding may offer some protection against the development of PPD. Formula feeding mothers may, therefore, be at increased risk for PPD.

on the web

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www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Screening/Pages/Maternal-Depression.aspx

CDC: www.cdc.gov/features/maternal-depression/index.html
March of Dimes: www.marchofdimes.org/pregnancy/postpartum-depression.aspx

Mayo Clinic: www.mayoclinic.org/healthy-lifestyle/pregnancy-week-by-week/in-depth/depression-during-pregnancy/art-20237875

National Institute of Mental Health:
www.nimh.nih.gov/health/publications/postpartum-depression-facts/index.shtml#pub9

Postpartum Support International:
www.postpartum.net

U.S. Department of Health and Human Services:
www.womenshealth.gov/mental-health/illnesses/postpartum-depression.html

World Health Organization:
www.who.int/mental_health/maternal-child/maternal_mental_health/en

- specific plan for how to carry out suicide/homicide
- means to carry out the plan, including access to weapons.

Plan and implementation

Use a proactive approach to develop a care plan for Maria. The plan should be collaborative and include a dialogue with Maria and her husband to set goals.

Nursing interventions should include:

- Provide anticipatory guidance regarding the realistic demands and lifestyle changes associated with parenthood.
- Encourage Maria to identify personal support systems.
- Educate Maria and her husband about signs and symptoms of PPD.
- Teach them how to recognize suicidal ideation.
- Instruct them about the prescribed medication regime.
- Provide emotional support for Maria and her family.
- Make a referral for home visits and individual or group therapy.
- Maintain communication through regularly scheduled phone calls.

Offer anticipatory guidance to Maria and her husband as new parents. Because Maria will be at home with her newborn while her husband works long hours, she may become isolated. It's beneficial to assist Maria with identifying support systems. You may suggest community resources, including a peer support group or parenting group. You should also encourage Maria to identify family members and friends to help her through her transition to motherhood.

Educate Maria and her husband about the signs and symptoms of PPD to anticipate and report to her healthcare provider. Maria should be screened for PPD using an instrument such as the PDSS and referred to a provider who specializes in treating postpartum mood disorders. It may also be beneficial for Maria to be seen by a home care nurse for further support and monitoring.

Evaluation

Evaluate and revise the care plan as needed. If the care plan is effective, PPD will be identified and promptly treated. Maternal, infant, and family safety will be maintained. Maria's medications may need to be adjusted by her healthcare provider if PPD doesn't resolve. Because antidepressants may take a few weeks to become effective, supportive care and closer monitoring may be necessary, such as home visits with a community health nurse. Maria's care plan should be evaluated on an ongoing basis and adjusted regularly to meet her healthcare needs and keep Maria and her family safe.

Supporting healthy families

Nurses are in a key position to perform routine screening for PPD, provide education, and ensure appropriate treatment referrals. Educating women and their families about PPD helps create a healthy perinatal and postpartum period, and contributes to a healthy family dynamic. ■

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