

# Guidelines for Treating Postpartum Mood Disorders

By Mary L. Obata, M.A.

Motherhood, one of the most joyful times in a woman's life, can also be the most stressful and challenging transition a woman will experience. The happiness a new baby brings is accompanied by changes for which a mother is usually ill prepared. In this society, mothers are expected to do it all alone with little support and rituals to help them through this transition. It also seems that few people are willing to openly discuss the possibility of difficulties being experienced during this "joyful time."

My own experience as a mother led me to feel that the best kept secret in the world was how challenging motherhood was going to be. I now work to inform and prepare other mothers and raise awareness to prevent postpartum adjustment difficulties. This article will outline the range of postpartum mood disorders, biopsychosocial risk factors for postpartum depression, screening tools available, suggested interventions, and recommended readings and resources.

## The Range of Postpartum Mood Disorders

**The Baby Blues** occurs in as many as 8 out of 10 women (80% of new mothers). It is a mild and temporary period of distress, usually experienced 3-14 days postpartum. Symptoms include: weepiness, anxiety, irritability, vulnerability, and feeling overwhelmed. They are similar to what a woman might experience during PMS. The Baby Blues usually occurs right after the birth and ends in a few weeks.

**Postpartum Depression (PPD)** usually occurs in at least one out of ten women (10-20% of new mothers). There can be early or late onset (up to a year postpartum). In late onset, there is a correlation between PPD and cessation of nursing, start of the menstrual cycle, or use of birth control pills (hormonal changes). Symptoms may include: the typical symptoms for depression such as tearfulness, irritability, sleeping or eating problems, inability to concentrate, loss of interest or pleasure, along with feelings of loneliness, isolation and despair. An inability to bond with the baby is of special concern, although it is normal for some mothers to take longer than others to establish that relationship and feel a strong connection.

**Postpartum Anxiety**, which is characterized by excessive anxiety and worry, is a common symptom and can occur along with the other disorders, although it is not formally identified as a postpartum disorder. According to Anne Dunnewold, past president of Postpartum Support International, postpartum depression is actually a misnomer. Postpartum anxiety is much more common than depression in new mothers, which makes sense in that mothers are adjusting to a whole new role and identity when they usually have had very little preparation and receive little support.

Specific anxiety disorders that can also occur are postpartum panic disorder (2% of new mothers) and postpartum obsessive compulsive disorder (2% of new mothers). In postpartum panic disorder, a mother experiences panic attacks with such symptoms as: heart palpitations, shortness of breath, chest pain, shakiness, dizziness, and a fear of going crazy. In postpartum obsessive compulsive disorder, a mother experiences recurrent, intrusive thoughts that can include thoughts of harm coming to the baby or harming the baby, which can lead to her avoiding the baby. Both disorders can occur in a mother who has had no previous history of them. Note: Even though anxiety is more prevalent, postpartum depression has been much more researched; therefore, I will use the acronym PPD as the umbrella term.

**Postpartum Psychosis (PPP)** has gotten the most media attention but is the least common form of postpartum psychiatric disorders, occurring in one out of a thousand women (.1% of new mothers). It has rapid onset, usually occurring within the first 4 weeks and most likely beginning 3-10 days

postpartum. Initially, the mother usually becomes manic or agitated and experiences extreme confusion. Symptoms include: irrational thoughts and incoherent statements, thoughts of harming self or baby based on delusional thinking, hallucinations, agitation or hyperactivity. What is especially concerning is that it is mercurial in nature, waxing and waning.

For example, a mother can appear normal for a period of time then lapse in and out of psychosis. Women suffering from PPP require immediate hospitalization because they are at risk for harming their babies or themselves. They usually quickly respond to anti-psychotic medication, but it is important to make sure that they are stabilized and remain on medication until they are out of danger. There is a strong relationship between Bipolar Disorder and PPP; many women who develop PPP suffer from an underlying Bipolar Disorder.

### **Biopsychosocial Risk Factors**

Biological, psychological, and social factors can all play a role in PPD. Hormonal and other physical changes that take place after childbirth can have a strong effect. Specifically, thyroid problems have been associated with depression.

Top risk factors include: personal or family history of mental health disorders, lack of support, low self-esteem, relationship or financial problems, a recent loss or disappointment, complicated pregnancy or birth, difficulties nursing or a difficult baby. (See Table 1.)

### **Screening Tools**

Unfortunately, screenings are not routinely done for PPD. It can easily go undetected and untreated. Mothers may feel shame in talking about their negative feelings and physicians may minimize a mother's experience. There are a number of screening tools available, though. Screenings should be given between 4-6 weeks postpartum and periodically throughout the first year.

The most common tool is the 10-item **Edinburgh Postnatal Depression Scale**, by J.L. Cox, J.M. Holden, & R. Sagovsky, (Detection of postnatal depression: development of the 10-item Edinburgh Postnatal Depression Scale, *British Journal of Psychiatry*, June 1987, Vol. 150). It can also be used to detect prenatal depression. For a free copy online go to: [www.granitescientific.com/EDPS.pdf](http://www.granitescientific.com/EDPS.pdf)

A more recent tool is the 35- item Western Psychological Services (WPS) **Postpartum Depression Screening Scale**, by C. Tatano Beck and R.K. Gable, and can be purchased at [www.wpspublish.com](http://www.wpspublish.com).

There is also a **Postpartum Depression Predictors Inventory (Revised)** by C. Tatano Beck, (*J Obstet Gynecol Neonatal Nurs* 2002 31: 394-402), which contains 13 risk factors with guide questions to be asked during the prenatal and postpartum period. For a free copy online go to: [www.lib.umich.edu/taubman/res/eres/Wismont/NU352/BeckCT.pdf](http://www.lib.umich.edu/taubman/res/eres/Wismont/NU352/BeckCT.pdf).

Postpartum Support International, [www.postpartum.net](http://www.postpartum.net), has a 40-item **Mills Depression & Anxiety Symptom-Feeling Checklist** by L. Mills that has not been researched but is very thorough in asking about the symptomology.

### **Suggested Interventions**

A good support network is vital for recovery. Counseling is extremely helpful in which a woman is validated for how challenging motherhood can be and encouraged to ask for more support from her husband as well as seek support from others. She also benefits from being able to acknowledge ALL her feelings, especially the possible hidden resentment she feels towards her baby for needing constant care and attention. It is important for a woman to understand that she can love her baby and have other feelings of frustration and resentment as well.

She may also experience feelings of loss, which can include: loss of identity, career, predictability, independence, and time for herself. Support groups are invaluable in which the woman can learn she is not alone in her struggle and hear from other women how they handle the stress of new motherhood.

Specifically, Interpersonal Psychotherapy, in which improving social functioning is the focus, and Cognitive Behavioral Therapy, in which replacing distorted thoughts with more realistic thoughts is the focus, have been shown to be effective methods of treatment. Although no research has been done to date on its effectiveness with PPD, EMDR is a highly effective technique for resolving trauma and working with negative cognitions.

Psychotropic medications can help a mother recover more quickly, especially when she is experiencing severe symptoms. A woman suffering from PPD should have a complete medical evaluation, including but not limited to a thyroid screening. When considering medication, she needs to have a psychiatric evaluation by a psychiatrist specializing in PPD. Women with thyroid problems often benefit from both thyroid and psychotropic medication. Hormonal medication such as estrogen is also being used experimentally and with reported success. While many mothers continue nursing when on medication, the type of medication chosen and whether a mother nurses should be the result of a risk-benefit analysis by a trained psychiatrist.

Recently, research has focused on techniques to improve mother-infant interaction for depressed mothers, since it has been discovered that the mother's depression can adversely affect her child's development. Amazingly, preliminary studies indicate that learning the practice of infant massage has been found to improve the interaction. Additionally, interactive coaching interventions in which instructions are given to the mother on how to positively interact with her infant are also beginning to be studied and look promising for improving responsiveness.

### **Recommended Readings and Resources for PPD**

The most important book for a pregnant mother to read to help her emotionally prepare for motherhood is "**Mothering the New Mother: Women's Feelings and Needs after Childbirth a Support and Resource Guide**" (2002) by Sally Placksin. It is based on interviews with hundreds of mothers and paints a realistic picture of motherhood and how best to prepare for the transition along with guidelines about how to set up your own support network. "**Mother Nurture: A Mother's Guide to Health in Body, Mind, and Intimate Relationships**" (2002) by Rick Hanson, Jan Hanson, and Ricki Pollycove is an important book for ANY new mother to read. It is the most comprehensive book out there on how to survive and enjoy motherhood. It looks at ways to lower your stress, regain energy, lift mood, prevent "Depleted Mother Syndrome," build teamwork and intimacy with your spouse, balance home and work.

The most popular books for mothers suffering from PPD are: "**This Isn't What I Expected: Overcoming Postpartum Depression**" (1994) by Karen R. Kleiman and Valerie D. Raskin and "**The Postpartum Survival Guide**" (1994) by Ann Dunnewold and Diane G. Sanford. A book written specifically for the husband and family is: "**The Postpartum Husband**" (2001) by Karen R. Kleiman. Professional books include: "**Postpartum Mood Disorders**" (1999) edited by Laura J. Miller, "**Evaluation and Treatment of Postpartum Emotional Disorders (Practitioner's Resource Series)**" (1997) by Anne Dunnewold, and "**Beyond the Blues: A Guide to Understanding and Treating Prenatal and Postpartum Depression**" (2003) by Shoshana S. Bennett and Pec Indman and is also good for mothers. "**Treating Postnatal Depression: A Psychological Approach for Health Care Practitioners**" (2000) by Jeannette Milgrom, et al contains an entire curriculum for facilitating a postpartum support group.

**Postpartum Support International**, [www.postpartum.net](http://www.postpartum.net), is the umbrella organization dealing with postpartum issues worldwide, and it has a very good website with a great deal of information

and reading materials. **Depression After Delivery**, [www.depressionafterdelivery.com](http://www.depressionafterdelivery.com), is the national organization with good information. **Postpartum Health Alliance**, [www.postpartumhealthalliance.org](http://www.postpartumhealthalliance.org), is a local San Diego organization, and it has a website with local information and resources.

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**TABLE 1****BIOPSYCHOSOCIAL RISK FACTORS  
FOR POSTPARTUM DEPRESSION**

<b>Biological</b>	<b>Psychological</b>	<b>Social/External</b>
personal or family history of depression or other mental health problems	low self-esteem	lack of support
experienced prenatal depression or previous PPD	feelings of inadequacy regarding childrearing (especially if inexperienced)	relationship problems
severe PMS – depression, irritability, etc.	perfectionist - high expectations of self as mother/high or unrealistic expectations of baby	a difficult baby (health, breastfeeding or sleeping problems, temperament)
reproductive problems, especially use of fertility drugs	role conflict, unrealistic role expectations	complicated pregnancy or birth (C-section or early/late delivery)
thyroid problems	attitude towards pregnancy, especially ambivalence or unwanted	separation from baby
hormones (changes in levels of estrogen, progesterone, cortisol, and prolactin)	negative feelings towards own mother or rejection of mother	a recent move or job change
cessation of nursing – prolactin	psychological vulnerability from trauma and abuse, especially sexual abuse	economic stress
commencement of menstrual cycle	unresolved grief over abortion, miscarriage or death of a child	recent death of a loved one
EEG sleep disturbance	weight retained after pregnancy affecting sense of well-being	any loss or disappointment