Postpartum Mood Disorders: What Family Physicians Should Know

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In today’s world, families are under increasing stress, from financial and time constraints, to family breakdown, substance abuse, and threats of violence. Family physicians are seeing an increase in psychosocial issues such as anxiety and stress-related disorders, often co-existing with and complicating medical problems such as diabetes or pneumonia. The psychosocial issues are often more difficult to diagnose and manage than are the medical problems—and all take place in the family context. Very often, the family is the key to dealing effectively with the whole spectrum of complaints, requiring a psychosocial assessment. In the crowded family medicine curriculum, this vital area of knowledge and skill is often ignored in favour of more clear-cut procedural skills.

To educate family physicians about dealing with families, a group of family medicine educators, practitioners and mental health professionals affiliated with the Department of Family and Community Medicine at the University Of Toronto founded the Working with Families Institute (WWFI) in 1985. The WWFI has developed various training experiences for trainees and practising physicians.

Goals
The goal of these modules is to provide a learning resource for physicians dealing with common medical and psychosocial issues that have an impact on families. The modules seek to bridge the gap between current and best practice, and provide opportunities for physicians to enhance or change their approach to a particular clinical problem.

The modules have been written by a multidisciplinary team from the Faculty of Medicine, University of Toronto. Each module has been peer-reviewed by external reviewers from academic family medicine centres across Canada. The approach is systemic, emphasizing the interconnectedness of family and personal issues and how these factors may help or hinder the medical problems. The topics range from postpartum adjustment to the dying patient, using a problem-based style and real case scenarios that pose questions to the reader. The cases are followed by an information section based on the latest evidence, case commentaries, references and resources.

How to Use the Modules
The modules are designed for either individual learning or small group discussion. We recommend that readers attempt to answer the questions in the case scenarios before reviewing the case commentaries or reading the information section.

The editors welcome feedback on these modules and suggestions for other modules. Feedback can be directed to Dr. Watson at dfcm.wwfi@utoronto.ca.

Acknowledgements
The WWFI is grateful to the Counselling Foundation of Canada for its generous educational grant in support of this project. The editors also thank Iveta Lewis (Librarian-DFCM) Brian Da Silva (IT consultant-DFCM), and Danielle Wintrip (Communications Coordinator-DFCM) for their valuable contributions to this project.

In addition, we thank our editorial advisory group including Ian Waters, MSW, Peter Selby MD, Margaret McCaffery, and William Watson, MD.

We also acknowledge the work of the Practice-based Small Group Learning Program of the Foundation for Medical Practice Education, on which these modules are modelled.

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Toronto, 2014
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SUMMARY
The postpartum experience can be challenging for mothers and their families because of stress from the birth and delivery, the transition to parenthood, and adjusted schedules and lifestyles. Heterosexual biological parents, same-sex parents, and adoptive parents all face these challenges. A relationship exists between mood disorders and pregnancy and the postnatal period. As well as the longstanding recognition that some women face specific risks in the early postpartum period, there is an increasing understanding of the effects of antenatal and postnatal mood disorders on pregnancy and the developing child. Although not distinctive in their presentation at this time, depressive and anxiety disorders are linked to adverse developmental outcomes for infants and may have profound implications for women and their families. These implications include obstetrical and neonatal complications, impaired mother-infant interactions, childhood developmental delay and subsequent mental health problems, and in extreme cases, maternal suicide and/or infanticide.\textsuperscript{1,2}

Psychosis in the antenatal period may pose particular management challenges. The distinct risk and clinical features associated with postpartum psychosis mean that clinicians must ensure effective and timely risk assessment, detection, and management.\textsuperscript{3}

Family physicians (FPs) are uniquely positioned in the health care system to help mothers and their families through this critical life transition. How can FPs recognize and improve their treatment of postpartum mood disorders and ultimately help mothers and families cope more effectively with this stage of the life cycle? This module emphasizes preventive, diagnostic, treatment, and communication techniques that can assist FPs in assessing the health of mothers and their families during the postpartum period.

OBJECTIVES
After completing this module, you will be able to
1. counsel parents and enhance your approach to caring for postpartum patients.
2. interview a postpartum couple as part of a “well-family” visit.
3. recognize and treat postpartum mood disorders.

Key Features
1. In the postpartum period, new parents, especially mothers, may face many challenges related to their past mental health history.
2. The FP’s role is to provide timely diagnosis and treatment, as well as to access community supports and make appropriate referrals.

Core Competencies
The core competencies addressed are related to the FP’s roles as a communicator, a family medicine expert, and a manager, and include the following:

1. Adopting a patient-centred approach
2. Determining the patient’s agenda and illness experience (i.e., through a focus on feelings, ideas, function, and expectations [FIFE])
3. Identifying and articulating patient goals and priorities, and negotiating patient priorities
4. Clarifying the patient’s understanding and developing a mutually agreed-upon treatment plan
5. Recognizing the typical and atypical presentation of common diagnoses, as well as possible life-threatening disease
6. Demonstrating an effective approach to the presentation of illnesses with a strong psychological component
Case 1: Maria, aged 22
You are seeing Maria, a new mother, with her five-day-old baby boy for a checkup. She had a normal pregnancy and delivery. Her baby is healthy but has lost 100 g since birth. John, the baby’s father, accompanies Maria and the baby. Maria is breastfeeding and having difficulty with the baby’s latch. She thinks she doesn’t produce enough milk. She looks very tired and on the verge of tears.

- How will you ask Maria about how she is feeling?
- How will you respond to Maria’s concerns about her breastfeeding problems and her baby’s weight loss?

Maria says she hasn’t been out of the house since the baby was born and she has been crying frequently. She worries about the house being a mess when visitors arrive. John is bewildered by her tears and asks you if her tearfulness is normal. He is concerned about how she is feeling and quietly asks if she is depressed.

- How will you respond to John’s question?
- What additional information would you want to obtain?
- How would you manage this situation to help Maria and her family?

Case 2: Renée, aged 30
Renée comes to the office with her four-week-old baby for a well-baby checkup. No partner or other support person is with her. She is new to the city and has few supports. She is breastfeeding, but is having difficulty establishing a good latch and is worried she doesn’t have enough milk for the baby, who has had adequate weight gain since birth.

- How will you respond to Renée’s concern? What question(s) will you ask next?

Renée is very anxious about the baby’s health. She has been unable to sleep, even when the baby is sleeping. You recall that she was quite anxious throughout her pregnancy and had difficulty sleeping in the last two months before her delivery.

- What does Renée’s inability to sleep reveal to you? What should you check for next?

Renée is crying frequently. Her partner, while concerned, has not been very supportive and has told her to “snap out of it.” Renée feels hopeless. From your interview with her, you discover that her mother had an episode of depression following Renée’s birth.

- How will you respond to Renée’s disclosure about her mother’s episode of postpartum depression?
- How can you help the “unsupportive partner”?
Case 3: Bridget, aged 25

Bridget is a single mother who has just given birth to a 4-kg, healthy baby girl. In hospital, Bridget seemed somewhat anxious. Before you see her the next day, the nurses take you aside and relate that she was acting strangely and had paranoid thoughts that someone was trying to take her baby away. When you visit her in her room, you notice that she is dishevelled and appears restless and irritable. She is speaking quickly and swearing, which is unusual for her.

• **What is the probable diagnosis?**

Her mother mentions that Bridget had a “nervous breakdown” when she was 18 and was hospitalized for two weeks because of acute excitement. She was discharged with medication that she took for six months. In addition, her father had a history of “manic-depressive” illness.

• **What can you say and do at this point?**

• **What is the next step if you determine Bridget has postpartum psychosis?**
INFORMATION POINTS

The Transition to Parenthood

1. Pregnancy is often a time of tremendous emotional and physical turmoil, both for the mother and for the people closest to her. When a couple learn they are going to have a baby, they generally experience excitement and anticipation, and possibly fear and/or ambivalence or aversion. The next few weeks are taken up with reorganizing their lives and making a multitude of decisions, including

   - whether to continue the pregnancy (in some cases).
   - choice of a physician.
   - place of birth (e.g., hospital or home).
   - prenatal classes.
   - type of delivery.
   - housing arrangements.
   - adjusting work commitments.

Then come thoughts about the baby and the many new physical, emotional, and financial stresses. Couples have concerns about breastfeeding, child care, daycare, and preschool, to name a few. In susceptible individuals, these stresses can lead to mental health problems such as anxiety and depression in both the mother and the father. This module does not address depression during pregnancy, which is related to postpartum depression, but Yonkers and Stewart have written useful reviews.

2. The postpartum period is a time when a woman’s identity may be challenged and her self-confidence threatened. She may be attempting to resolve conflicts about her body image and role identification, and to adapt to changes in her relationship with her parents and partner, the nature of the partnership, the beginnings of motherhood, and caring for an infant. She is beginning to develop her own philosophy of motherhood, based on her family of origin and perception of societal expectations. In addition, some women may be biologically susceptible to mental health problems during periods of reproductive transition. At this point, the FP can address this area by discussing the mother’s and the father’s perception of their roles, with open-ended questions such as “How has life changed for you since the birth of your baby?”

3. Marriages are placed under considerable stress when an infant joins the family; 15% to 20% of marriages break up within two to three years after the birth of a child. During that time, a link appears to exist between marital stress and the sharing of child care responsibilities and household tasks. Even with the best of intentions, the burdens of parenting are rarely shared equitably. Among many troubled couples, the seeds of problems are sown long before the baby arrives. The FP may be able to help couples realize the stress of the postpartum period and provide timely support and interventions, such as marital counselling, when these are indicated.
4. In traditional families, the person closest to the mother is usually the baby’s father. In some situations, the partner may be a man who is not the biological father, or the mother’s lesbian partner. In addition, even when no partner is actively involved in the mother’s life, feelings and fantasies about her baby’s father may play an important role in her experience of her pregnancy and parenthood. During the postpartum period, the new father or other partner may also be experiencing difficulty and may have feelings of exclusion from the close mother-infant relationship. In addition, he may have concerns about his ability to provide for his new family, his ability to care for a baby, his lack of free time, and his disrupted sleep. He may also feel ambivalent about his wife’s breastfeeding and may not provide adequate support.

5. The FP can provide support and guidance to the couple in the postpartum period, emphasizing the importance of the partner’s role. In providing family-centred care, the FP can help establish a good working relationship with the father or other partner, encouraging his involvement in the care of his newborn and educating him about the positive impact he can have on his child for years to come. When a mother develops a postpartum mood disorder, the father/partner may be an important source of support and information.

Early well-baby visits in the postpartum period provide excellent opportunities for assessing not only the newborn’s health, but also the family’s functioning. FPs should make every effort to invite the father/partner to these visits and to address with the couple, even briefly, how family life has been since the baby’s birth. These office visits could be called “well-family visits,” and should be used whenever possible to assess the health of the entire family.

The following are some specific questions to ask the mother and, when appropriate, the father/partner during early postpartum visits:

- Are you getting out?
- Do you have anyone who can help?
- Are you able to sleep when the baby is sleeping?
- Are you eating, and, if so, what are you eating?
- How is your energy level?
- Are you having any scary or unusual thoughts about yourself or the baby?
- How do you like being a mom/dad?
- How are things at home?
- Your life must feel upside-down at this point. Are you okay?

The Role of Fathers/Partners

6. Depending on the father’s/partner’s mental health, the birth of a child may affect him/her in the postpartum period, causing an increased level of confusion and fear. He or she may even experience a crisis in his or her own mental health and the relationship.
The FP should educate the father about the importance of his support and patience toward his partner; monitor his mental health, and encourage his ongoing involvement.\textsuperscript{1,10} The FP should also be aware that the father/partner may develop a postpartum mood disorder, and may require treatment.

7. Men and women have different passages into parenthood. Fathers experience changes in their sense of responsibility, in their relationships with their partners, and in their feelings about themselves. They often describe major disruption in their lives, with feelings of fear, confusion, and much concern for their partners.\textsuperscript{7} Fathers frequently complain that mothers shut them out of their babies’ lives and that health professionals do not include them in decisions about the birth and care of the baby. While mothers may complain that the overwhelming load they carry is taken for granted, new fathers may experience feelings of exclusion from the close mother-infant relationship. In addition, a father may have concerns about his ability to provide for his new family, his ability to care for a baby, his lack of free time, and a disrupted sex life and sleep. He may also feel ambivalent about his wife’s breastfeeding.

Again, the FP can provide support and guidance to the couple, emphasizing the importance of the father’s role.\textsuperscript{1,12} Research indicates that a father’s positive involvement has a positive impact on his child’s future behaviour, intelligence, and relationships.\textsuperscript{12} When fathers adapt poorly, particularly when their relationships with their partners are unhappy, the entire family’s well-being is affected negatively.

**Parenting and Emotional Attachment**

8. Family physicians should assess the maternal-child emotional attachment at each postnatal contact through direct questioning (see Table 1). Home visits by the FP or a public health nurse can be used as an opportunity to promote support and positive parenting. Women should be encouraged to develop social networks, as these promote a positive mother-baby interaction. Group-based parent-training programs designed to promote emotional attachment and improve parenting skills should be available to parents who wish to access them. Health care providers should offer fathers information and support as they adjust to their new role and responsibilities within the family unit.\textsuperscript{10,12,13}

9. The FP has the opportunity to develop a trusting relationship with fathers/partners, which may help support them during the postpartum period. Many opportunities exist to involve fathers/partners, including prenatal office visits, well-baby visits, and planned visits for physical examinations. The father/partner has an important role to play in supporting the mother during the postpartum period.
### Table 1

**Suggested questions for assessing postpartum functioning**¹,²

<table>
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<th><strong>Global questions:</strong></th>
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<tr>
<td>• How have things been for you since your baby’s birth?</td>
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<td>• Are you eating? Sleeping? Getting out?</td>
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<td>• Are you having any scary thoughts about yourself or the baby?</td>
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<td>• What have been the most difficult adjustments for you?</td>
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<td><strong>Relationship with partner:</strong></td>
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<td>• Has your partner been able to help you since the baby’s birth?</td>
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<td>• The relationship between partners changes when a baby is born. How have these changes affected you? Are you concerned about these changes?</td>
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<td>• With all the demands of being a new mother, some women are not eager to resume sexual activity. Do you have any concerns in that area?</td>
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<td>• Some women experience vaginal dryness from lack of estrogen during breastfeeding. Have you found this to be a problem?</td>
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<td><strong>Mother’s role:</strong></td>
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<tr>
<td>• Some women feel insecure about their ability to meet their baby’s needs. Have you felt any concerns in that area?</td>
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<tr>
<td>• Do you worry about being a good mom? This is a very common concern and far greater if you have a mood disorder.</td>
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<td><strong>Mother’s identity and emotions:</strong></td>
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<td>• A woman’s body shape returns to its pre-pregnancy state slowly, and waiting for that to happen can be frustrating. Could you share your thoughts on this?</td>
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<td>• Since the baby was born, have you noticed that you are easily upset about small matters, or that you cry easily?</td>
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<tr>
<td><strong>Father’s role:</strong></td>
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<tr>
<td>• How has becoming a parent changed your relationship with your partner? How has it affected your free time?</td>
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<tr>
<td>• Do you have pressures at work? A lack of sleep? A lack of a sex life?</td>
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<tr>
<td>• Friends and people at work often tend to underestimate the effect a baby’s birth can have on fathers/partners. Has this happened to you?</td>
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<td><strong>Extended family and supports:</strong></td>
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<td>• How are other family members adjusting to the new baby?</td>
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<tr>
<td>• Are you happy with the amount of care that your family is showing toward you and your new baby?</td>
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*From: Letourneau et al., 2012; Yonkers et al., 2011*
Normal Postpartum Reactions (the Baby Blues)

10. Up to 70% of postpartum women experience the “baby blues” and 10% to 20% experience a major mood or anxiety disorder that can affect their quality of life and ability to fulfill their usual roles as mothers, partners, and employees. Unfortunately, depression and anxiety are seriously undertreated during pregnancy and after childbirth, which increases the vulnerability of infants, women, and families.

At each antepartum and postnatal contact, women should be asked about their emotional well-being, family and social support, and their usual coping strategies for dealing with day-to-day matters (see Table 2). A woman and her family and/or partner should be encouraged to discuss any changes in mood, emotional state, and behavior that are outside the woman’s normal pattern. Between 60% and 85% of new mothers experience the postpartum blues or “transitory baby blues,” characterized by mild depressive symptoms, tearfulness (often for no discernible reason), anxiety, irritability, mood lability, increased sensitivity, and fatigue. The blues typically peak four to five days after delivery, may last hours to days, and resolve by the 10th postpartum day. Diagnosis should be made as soon as possible. Subtle changes in behavior, often noted by the partner, may be the first symptom of postpartum depression (see Table 2).

Table 2

National Institute for Health and Clinical Excellence (NICE) diagnostic criteria: postpartum depression\(^\text{14}\)

All women at booking and at postnatal checks should be asked the following screening questions:

- During the past month, have you often been bothered by feeling down, depressed or hopeless?
- During the past month, have you often been bothered by having little interest or pleasure in doing things?

If the woman answers “yes” to both questions, a further question should be asked:

- Is this something you feel you need or want help with?

11. The depressed mood or blues usually remit spontaneously with no special treatment other than support. The mood often coincides with rapid hormonal shifts, as well as the reality and practicalities of coping with a new baby. Supportive treatment is indicated. Mothers can be reassured that dysphoria is transient and most likely due to biochemical changes. The realization of the monumental task of mothering is coupled with major hormonal shifts as estrogen and progesterone levels drop dramatically and prolactin levels increase. At this point, the FP should also monitor mothers for development of more severe psychiatric disturbances, including postpartum depression or psychosis. This may be accomplished through
more frequent office visits to assess mood and overall health, as well as referral to a psychiatrist or other mental health professional.

12. Often a new mother’s sleeping and eating routines are repeatedly interrupted by the need to care for the baby. The new mother who is not clinically depressed may respond to a good night’s sleep or an outing while someone else cares for the baby. However, mothers who are having difficulty may be reluctant to talk openly about their problems. Sometimes, simple questions may yield information that can alert the FP to the need for closer monitoring and more frequent office visits. These questions include the global questions listed in Table 1.

13. Some new mothers experience some form of scary thought (e.g., a knife in the baby, the baby drowning, the baby falling downstairs and its head smashing open, someone kidnapping the baby). In most cases, these thoughts are transient, but sometimes these thoughts or images occur repetitively and are difficult to control. They may scare the mother and she may not talk about them unless asked about them directly. The FP should explain that such thoughts are not uncommon, but require treatment if they become intrusive and difficult to control. A history of these thoughts in the mother should not be dismissed; she should be monitored by close follow-up and, if necessary, further assessment by a psychologist or a psychiatrist.

14. Although the blues are short-lived for most women, evidence suggests that women who experience them have an increased risk for a postpartum mood disorder later in the postpartum period, especially if the blues symptoms are severe. In one study, among women who met the criteria for a postpartum mood disorder six weeks after delivery, two-thirds had had the “baby blues.” Similarly, the 10% of childbearing women who experience the “highs” (mild euphoria, energy) within the first few days after delivery are more likely to be depressed or have another mood disturbance several months later. Therefore, subclinical mood swings in either direction are an indication for more intensive follow-up later in the postpartum period. If these symptoms are severe or last longer than 10 days, the diagnosis is likely postpartum depression or postpartum psychosis, not postpartum blues.

15. Family physicians may assume that extended families will be supportive, but sometimes they are not. Health care professionals should be aware of the risks, signs, and symptoms of domestic abuse and know whom to contact for advice and management, following existing legal guidelines. Possibly the new parents are being inundated with well-meaned advice. Here, the FP needs to reinforce the new parents’ ability to know their baby’s temperament and trust their instincts. However, in the face of a postpartum mood disorder, this advice needs to be modified according to the mother’s mental state (see Table 3).

Finally, consider who else can help, such as relatives or friends, and consider asking the mother to bring a support person to the next visit (see Table 3).
Table 3

Discussion subjects in the first few weeks after a baby is born

- Mother’s concerns
- Baby’s day/night reversal
- Feeding concerns
- Father’s/partner’s concerns
- Re-establishing the relationship as a couple
- Mother’s self-image and expectations of herself
- Support system—friends and/or family
- Negotiation of parenting roles and responsibilities

Prevention and Detection of Postpartum Mental Health Issues

16. Postpartum women are particularly vulnerable to a variety of social factors, such as
- the amount and nature of support.
- a poor marital relationship.
- stressful life events.
- stress associated with infant care.
- a negative birth experience.
- a lack of social structuring of the postpartum period.
- being a recent immigrant or refugee.

Postpartum mood disorders affect 10% of women, and postpartum anxiety disorders may be even more common. Common symptoms of depression in the postpartum period include sustained low mood, reduced interest in the infant, and inability to sleep (even when the baby is sleeping). Mood and anxiety disorders commonly present with anxious thoughts related to themes such as worries about infant health or safety and parenting ability. The risk of major depression requiring admission to hospital is greater in the postpartum period than at any other time in a woman’s life.

One important diagnostic tool is the Edinburgh Postnatal Depression Scale (EPDS) (see Appendix 1). It is a self-rated, validated screening instrument specifically developed for primary care. Studies using this tool show much greater identification of postpartum depression compared with routine clinical evaluation. This scale also assesses anxiety symptoms and can be used to screen for postnatal anxiety disorders. A shorter screening tool from the UK, the National Institute for Health and Clinical Excellence (NICE) Guidelines, may also be effective (see Table 2). The NICE Guidelines recommend that women be proactively screened for postnatal depression and high-risk patients identified. The guidelines advise that health professionals, including FPs, midwives, obstetricians, and health
visitors, should ask about the following issues when women present for booking and at the postnatal check:

- Past or present severe mental illness, including schizophrenia, bipolar disorder, psychosis in the postnatal period, and severe depression
- Previous treatment by a psychiatrist/specialist mental health team, including inpatient care
- A family history of perinatal mental illness

17. Postpartum mental health problems frequently go undetected for several reasons:

- Some characteristics of “normal” adjustment may be difficult to distinguish from the early symptoms of an emotional disorder. These include anxiety, insomnia, fatigue, episodes of crying, and in some cases, dysphoria.
- Many women experiencing symptoms of postpartum emotional distress may be reluctant to reveal them to those around them. At a time when they are expected to feel elated and happy, such symptoms may lead to embarrassment and shame. In turn, this shame may cause affected women to remain silent about their distress, even when they are asked about it directly.
- Parents-to-be receive considerable preparation for the physical aspects of birth. Unfortunately, they are rarely prepared for the emotional challenges of parenthood, or given information about the stressors they may face. Thus, when disturbing feelings and events arise during the postpartum period, they may conclude that their reactions are unusual and reflect their own inadequacies as parents.
- Peers and professionals alike may dismiss postpartum women’s emotional concerns. Distressing feelings may be attributed to “hormones” and passed off as irrelevant and unimportant. Like affected women themselves, peers and professionals may also feel that such feelings reflect some weakness in the woman.
- Some women hide postpartum depression extremely well. They are afraid and ashamed to reveal how they feel, in case someone will think they are crazy or will take their child away.

18. Detection and management of postpartum mental health disorders is essential for the child’s health. Maternal depression may be accompanied by delayed mother-infant attachment and even the mother’s rejection of the child. Significant behaviour problems, such as sleep and eating disorders, temper tantrums, delayed language development, impaired social function, poor attention skills, and predisposition to depression have been found in the children of depressed women. Severe maternal mental health problems may be accompanied by obsessional thoughts of harming the child and, in some cases, psychosis. Although infanticide is extremely rare, two-thirds of infanticides are committed by mothers who are psychotic and the most vulnerable time for the infant is during the first six months of life.  

19. Some evidence indicates that early identification and intervention for women at risk of postpartum mood disorders may preserve family
function, save marriages or partnerships, and provide a better environment for the child.27,28

Over the past few decades, the research literature has consistently described the postpartum period as one of high risk for the development of emotional disorders.12,28,29 Support groups appear to be beneficial and participation in them can be arranged before the infant’s birth, as families often do not have the energy to do this after the infant arrives.30 In addition, lack of social support is one of the strongest risk factors for postpartum depression. The FP can encourage mothers and their partners to identify and use meaningful supports, such as mothers-and-tots groups and drop-in centres. Accepting needed help from others and setting boundaries also are important for the new nuclear family. Appropriate limits should be set for well-meaning visitors, and the new family should not feel obliged to entertain at the expense of sleep and family time.

20. Because of the many opportunities for ongoing contact during this critical time of the family life cycle, FPs are in an ideal position to provide comprehensive care throughout this life stage.11 Opportunities may occur during a prenatal visit, a well-baby visit, or another unrelated visit, such as a visit for a sick baby. Family physicians should use these opportunities to do a quick mental health checkup with their postpartum patients.

**Postpartum Major Mood Disorder**

21. Also known as postpartum depression, this condition develops in about 10% to 20% of women. Typically, depression is considered “postpartum” if it begins within one year after childbirth. The symptoms accumulate over time and women often continue to “cope” until the symptoms become a crisis. The depression disorganizes and disrupts a mother’s capacity to care for her infant and jeopardizes the development of a healthy attachment between mother and infant. Early symptoms of depression include sleeplessness, loss of self-esteem, irritability, and sadness (see Appendix 2). More serious symptoms include anorexia, obsessive symptoms and compulsive behaviour, and panic. Estrangement from the newborn, which may be characterized by the mother’s despondency and a striking lack of interest in her infant’s activities, should be viewed as a disturbing symptom.2,28,29

22. Several groups of women have a much higher likelihood of developing depression during the postpartum period (see Table 4). For those with a history of a depressive illness, the risk of recurrence is about 30%. Recurrence of depression is much higher in those with bipolar depression than in those with unipolar depression. The postpartum depression rate is almost 30% in adolescent women. A woman who has experienced one postpartum depression is at increased risk for subsequent postpartum episodes, as is a woman who has had severe affective symptoms premenstrually. Up to 70% of women with previous postpartum depression will have a subsequent episode, especially if they have a family or personal history of bipolar affective disorder.2,11
In addition, research suggests that recent immigrant and refugee women, as well as women in urban centres, have a higher incidence of postpartum mood disorders.\textsuperscript{20,21,31}

### Table 4

**Risk factors for postpartum major mood disorder**\textsuperscript{26}

<table>
<thead>
<tr>
<th>Pregnancy and psychiatric history</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Depression or anxiety in pregnancy</td>
<td></td>
</tr>
<tr>
<td>Ambivalence about maintaining the pregnancy into the second or third trimester</td>
<td></td>
</tr>
<tr>
<td>History (or family history) of depression or bipolar illness</td>
<td></td>
</tr>
<tr>
<td>History of postpartum depression</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Current life situation</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of social support</td>
<td></td>
</tr>
<tr>
<td>Stressful recent life events</td>
<td></td>
</tr>
<tr>
<td>Lack of a dependable relationship with partner and parents</td>
<td></td>
</tr>
<tr>
<td>Being a recent immigrant or refugee</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Early family life</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of a nurturing relationship with mother and father</td>
<td></td>
</tr>
<tr>
<td>History of abuse</td>
<td></td>
</tr>
</tbody>
</table>

23. Mounting evidence indicates that chronic maternal depressive illness affects the quality of the mother’s relationship with her child and the child’s cognitive and social development. Depressed mothers have shown less social interaction and play facilitation with their children. Family physicians should be aware of this problem and educate families about the need for other sources of interaction for the child, outside the mother-child relationship, such as daycare, caregivers, and other family members (see Table 5).\textsuperscript{1,28}
### Table 5
**Helping the depressed mother**

1. Offer supportive counselling: Enlist the support of the father/partner or other significant support person.
2. Encourage the mother and father/partner to obtain additional home help from family, friends, or hired help.
3. Initiate psychotherapy by referral to a psychologist, psychiatrist, or postpartum program.
4. Discuss antidepressant medications and encourage their use in severe depression or if counselling doesn’t help within two to four weeks.
5. Consult with a psychiatrist interested in postpartum depression.
6. Encourage the mother to join a self-help support group. Social isolation often contributes to postpartum depression.
7. Assure the mother frequently that her illness is common and treatable. Reinforce that she is not to blame for her feelings.
8. Offer educational material and support to the father/partner and family.
9. Continue to assess the attachment bond between the mother and child and monitor any physical or psychological risk to the child.
10. Treat the woman and her family as participants in, not merely recipients of, treatment. This is essential for successful treatment.

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24. A patient who is mildly depressed is usually unable to enjoy activities, lacks enthusiasm, and sleeps and eats less than before, but is still able to function. There is one caveat. A high-functioning woman may manage, by heroic efforts, to appear normal despite fairly serious depression. Observation is important in the recognition of depression, but the diagnosis must be made by assessment of signs and symptoms such as profound inner psychic pain, a preoccupation with death and disaster and/or thoughts of suicide, and considerable disturbances in energy, sleep, and appetite. One should be especially concerned about women who are extremely sleep deprived, or who are unable to get back to sleep once their babies have gone to sleep. Although a newborn’s demands make lack of sleep and fatigue common during the postpartum period, consistent problems returning to sleep or chronic and unrelieved sleep deprivation is not typical. Organic causes of depression (e.g., anemia, thyroid disease, vitamin B12 deficiency, or medication side effects) should be investigated.⁴,¹⁵,¹⁸
25. With early detection and appropriate referral and treatment, postpartum depression has a good prognosis. Treatment options include a combination of one or more of the following: 
   - Participation in a postpartum support or self-help group
   - Psychoeducational interventions/supportive therapy for mild depression
   - Cognitive behavioural therapy or interpersonal psychotherapy for mild to moderate depression
   - Individual psychotherapy (with or without family/couple therapy) and antidepressant medication for moderate to severe depression
   - Couple counselling when indicated
   - Physical activity

Nonpharmaceutical management of depression may include exercise. The NICE Guidelines recommended that structured exercise be considered as a treatment option for patients with depression. Structured exercise is exercise undertaken three or more times each week at an intensity sufficient to provide an energy expenditure of 70% to 80% of heart rate reserve. The guideline recommendation was based largely on a Cochrane Database Systematic Review and meta-analysis, which indicated exercise is clinically effective.  

26. Mild to moderate depression can be treated effectively with psychotherapy and/or pharmacotherapy. Women with mild depression may benefit from self-help groups. Controlled trials indicate that enhanced social and psychological support during pregnancy has a number of beneficial psychological and behavioural effects. Women who receive such support are less likely than women in control groups to feel unhappy, nervous, and worried during pregnancy, and are less likely to have negative feelings about the forthcoming birth. However, even optimum postpartum support may not prevent or help a serious mood disorder.

For FPs, the most familiar modality of psychotherapy is supportive psychotherapy, in which the patient’s fears of new responsibilities and roles are discussed and coping skills are encouraged. A recent Cochrane Database Systematic Review indicates that professional and/or social support interventions (e.g., emotional support, counselling, home visits) are associated with reduced depression at 25 weeks’ postpartum. However, supportive treatment alone is often insufficient for major postpartum depression.

Mild to moderate depression may be effectively treated with interpersonal therapy or cognitive behavioural therapy to modify dysfunctional thoughts and behaviours. In depressed antepartum women, interpersonal therapy focused on difficulties with role changes has also been shown effective in reducing postpartum depression. 

Pharmacotherapy can be prescribed even for nursing mothers (see “Drugs and Breastfeeding”). Although no randomized, controlled trials have
assessed adverse events in infants exposed to antidepressant drugs through breast milk, observational data have been reassuring. In addition, breast milk exposure is not an indication to change antidepressant treatment if it is working. First-choice drugs are the selective serotonin-reuptake inhibitors (SSRIs). Sertraline and paroxetine are preferred as they are not usually detectable in exposed infant serum. In addition, no clear contraindications exist for any other SSRIs or serotonin-norepinephrine-reuptake inhibitors (SNRIs) during breastfeeding, even if the drug does pass into the infant’s bloodstream.

When a poor treatment response occurs with two or more SSRIs or SNRIs, treatment with tricyclic antidepressants may be indicated for the mother and have been used during lactation without evidence of serious adverse events. In all cases, infants should be monitored for excessive sleepiness or other behaviour changes. Electroconvulsive therapy (ECT) also is effective and leads to rapid improvement in severe depression.

27. In moderate to severe depression, antidepressant medication may be required, but physicians should be aware of the risks associated with psychotropic drugs in later pregnancy. These include neonatal toxicity or poor neonatal adaptation following delivery, as well as the possibility of a long-term impact on the infant’s neurodevelopment. By the time a postpartum woman agrees to use medication, she already may be “in crisis.” She needs to see some rapid improvement because she has to cope with a new baby. If insomnia is a prominent symptom, sleeping medication in the form of low-dose benzodiazepines is useful while the antidepressant is taking effect. Sleep is critical to her recovery and her ability to cope. Antidepressant medication is effective in the treatment of postpartum major depression (PMD), but may have small but definite risks, such as miscarriage, preterm birth, cardiac defects (following first trimester exposure), persistent pulmonary hypertension of the newborn (following second and third trimester exposure), and neonatal adaptation syndrome (a self-limited withdrawal syndrome seen after late third trimester exposure).

Because of its association with harms to the fetus and neonate, paroxetine generally should not be initiated as first-line therapy in pregnancy. For women who have already been prescribed paroxetine, an evaluation of individual risks and benefits should be completed before a decision is made to continue use or switch to another antidepressant.

The choice of an antidepressant for a pregnant patient should take into account implications for breastfeeding. As the evidence base for safety of antidepressant prescribing in pregnancy is a rapidly developing area, clinicians should update their knowledge frequently.

28. If symptoms are severe, if the FP is inexperienced in the use of antidepressant medications, or if response to treatment does not occur within four weeks, medication can be managed in conjunction with a psychiatrist.
29. The depressed patient should also be monitored for thoughts of suicide or infanticide, emergence of psychosis, and response to treatment. The family should be involved in the process, both in providing their care and addressing their concerns, and also in providing important feedback about how the mother is functioning in relation to her mental state. For some women, the course of the illness is severe enough to warrant immediate referral to a psychiatrist and possible hospital admission.5

Postpartum Psychosis

30. The distinct risk and clinical features associated with postpartum psychosis mean that clinicians must ensure effective and timely risk assessment, detection, and management. Psychosis is the most worrisome of the postpartum mood disorders and occurs in two of every 1,000 births. Women with postpartum psychosis may present with psychotic depression, paranoia, mania, schizophrenic symptoms, or an organic-appearing presentation such as confusion. Psychotic thinking includes a break from reality; mild symptoms of anxiety and emotional lability may progress rapidly—sometimes within a matter of hours—to profound psychosis. The mother is no longer able to distinguish her thoughts from reality and may develop fixed false beliefs (delusions) about herself, her infant, or others around her, with comments such as “I hate it when he does that!” or “I don’t think I can do this.” The risk of postpartum psychosis is increased for women with prior postpartum psychosis, and is also elevated for those with a history of bipolar mood disorder. Any significant and unexpected change in mental state in late pregnancy or the early postnatal period should be closely monitored and should prompt referral to mental health services for further assessment.5 Once a woman has had an episode of postpartum psychosis, she has a 30% to 50% risk of recurrence with each subsequent delivery.2,26

31. The peak onset of psychotic symptoms is three to 14 days after delivery, but the risk remains elevated for three months after delivery. It can also occur at weaning. While psychosis is relatively rare, the risk is still 10 to 15 times greater during the postpartum period than at other times during a woman’s life.2 Up to 40% of women with this disorder will go on to develop a relapsing psychotic illness, usually bipolar affective disorder, which recurs during times unrelated to pregnancy.

32. The course of this condition is variable and depends on the type of underlying illness. In mothers with bipolar or schizoaffective disorders, the time to recovery is three to six months. The most impaired level of functioning during follow-up care is among women with schizophrenia.18 The main risk factors for postpartum psychosis are a personal history of a psychotic illness, especially bipolar and schizoaffective disorders, and a family history of psychiatric illness, especially bipolar affective disorder. Some evidence also indicates that sleep deprivation is a major risk factor for psychosis in women with bipolar mood disorder.27

33. Management requires urgent psychiatric consultation, along with pharmacological treatment and hospitalization. A mother should not be left
alone with her baby and should be escorted to the emergency department. Some women require ECT if drug treatment fails, or if symptoms are severe or uncontrollable. Women with psychosis will usually have difficulty caring for their infants, and may have delusions leading to thoughts of self-harm and harm to the infant. As with any serious medical diagnosis, the partner and other family members must be educated and involved, with appropriate attention to confidentiality. This will assist in the patient’s compliance with the treatment program, and also in the family’s understanding of the nature of the problem.

Treatment requires ongoing medication and extensive follow-up care, along with support and active help from the family. When possible, and if doing so is safe, the baby should be kept near the mother so that feeding can resume once psychosis has resolved. The rate of hospital readmission is increased if mothers are separated from their babies for an extended time during the treatment of their illness. The partner and/or family should be made aware of the chronic nature of this illness and given some practical advice on how to provide support the mother, such as help with child care and household chores, as well as respite time.

**Other Postpartum Mental Disorders**

34. Physicians should be aware of the other postpartum mental disorders, including obsessive-compulsive disorder (OCD), other anxiety disorders, and attachment disorders. Some women may not feel depressed, but may feel very anxious. Approximately 50% to 60% of the women who contact self-help groups have some symptoms of anxiety. Women with perinatal mood disorders may present with a range of these symptoms. During the same day, they can be sad, anxious, constantly washing and cleaning, or bone tired and yet unable to sleep. The diagnosis can be difficult, because the symptoms do not always fit neatly into the DSM-IV criteria.

Postpartum anxiety and/or panic disorder can be characterized by
- intense anxiety and/or fear.
- rapid breathing.
- a fast heart rate.
- a sense of doom.
- hot or cold flashes.
- chest pain.
- shaking.
- dizziness.

Postpartum distress may also include obsessive-compulsive features. Obsessive-compulsive disorder (OCD) can occur for the first time in women following childbirth. If a woman has a history of OCD, her symptoms may intensify. Symptoms include
- excessive checking or cleaning, or rituals that the woman knows are abnormal.
- intrusive, repetitive thoughts (including thoughts of harming the baby).
• avoidance behaviour (i.e., avoiding the baby to alleviate intrusive thoughts).
• anxiety.
• depression.

Obsessional thoughts are intrusive and difficult for the mother to control, although she neither desires nor intends to act on them. The woman often finds these thoughts frightening and out of character. Fortunately, postpartum anxiety disorders and OCD usually respond to SSRIs, but they may require higher doses than those needed for depression.

Acute schizophrenia symptoms may mimic those of bipolar postpartum psychosis. Expert psychiatric consultation is required for accurate diagnosis and treatment of the acute episode.

**Referral to Mental Health Professionals**

35. The referral process depends on the FP’s experience and skill level, and the severity of the depression. Some FPs will refer depressed patients at the outset, preferring not to treat psychiatric illness. Others may have skills in this area and manage patients’ care themselves.

Some patients may request a mental health referral or have a history of treatment with a particular clinician. Many practitioners can perform supportive psychotherapy. Social workers may also have special expertise in couples therapy and connecting patients with other community resources. Psychologists are trained to perform psychotherapy and psychological testing. Psychiatrists are the mental health professionals of choice whenever a question of medical differential diagnosis exists, when postpartum psychosis or suicide is possible, or when difficulty in medication use and/or side effects are evident.

Often, patients and their families can be reluctant to agree to a referral to a psychiatrist for consultation. The following suggestions are helpful for achieving an effective referral:

• Ground your concern in the patient’s behaviour and statements, and the reports of the partner or other individuals close to the mother. Involve these people early in the diagnostic assessment and management of PMD, and keep them involved in the decision-making process.
• Consider making statements such as the following:
  • “I’m worried about your sleeplessness and loss of energy.”
  • “I feel that you are having trouble looking at me today. It appears that you are staring at the floor and that you’ve lost your usual zest. Do you feel as if you might burst into tears?”
  • Be open about the diagnosis you are considering: “It’s possible that you have depression (or anxiety).” Tell the patient that depression (or an anxiety disorder) is a genuine disease, and that it is not her fault. Often, a helpful approach is showing the patient a written document or pamphlet listing the signs and symptoms of depression and anxiety.
disorders. Sometimes “depression” may seem a misnomer because often the main complaint is anxiety. Women may associate depression with sadness. Often they will deny they are depressed, because they believe they are not supposed to feel this way after the birth of a baby. A discussion of a “mood disruption or disorder and hormonal changes after pregnancy” is easier for women to accept and understand.

- Identify the mental health professional as a member of the treatment team or a colleague whom you know and in whom you have confidence: “I would like you to see my colleague, Dr. Jones, who often works with us.” Let the patient know that you are making a referral to someone who will help her enjoy her family again. This likely will make the referral less frightening.
- Ask the patient for her reaction to your suggestion. If she is hesitant, encourage her to think it over and discuss it with her family or friends.
- Make very clear the fact that you will continue to provide care for the patient. Ask her to call you to tell you how she felt about her meeting with the mental health professional, and advise her to schedule a follow-up visit with you.
- If you assess the patient and determine she is suicidal or unable to care for her infant, a psychiatrist should see her the same day. If she is acutely suicidal, she must be personally escorted into a safe environment, such as an emergency department, where a psychiatrist can be consulted and she can be assessed for hospitalization.

**The Role of Home Visits**

36. Home visits are an important part of any family-oriented medical practice, and especially so after the birth of a baby to assess how a family is functioning, how feeding is going, and what kind of help and support the mother is receiving. Not every FP is able to do house calls, and the public health nurse is an important resource. In some jurisdictions, the public health nurse can provide home visits and ongoing support to mothers and their families in conjunction with the family doctor.\(^\text{18}\)

**Drugs and Breastfeeding**

37. Most drugs pass through breast milk to the infant.\(^\text{34}\) Postpartum mothers may be reluctant to take medications because of concerns about breastfeeding and the presence of medication in breast milk. The FP should address these concerns with the patient. Antidepressant drugs are not found in large concentrations in breast milk, and they have no obvious, immediate deleterious effects on the infant.\(^\text{36}\) However, the effects on the infant’s developing neurotransmitter system are unknown. Some psychotropic drugs do appear to present some risk to the breastfeeding infant. Benzodiazepines may produce lethargy or impaired temperature regulation and may also cause jaundice in premature infants. Traditionally, lithium has been considered contraindicated in breastfeeding women because of concerns about lithium toxicity in the infant. However, because it is so efficacious, experts are reconsidering its use in breastfeeding women, with close monitoring of lithium levels and complete blood counts in the infant.\(^\text{36}\) Major tranquilizers have not been associated with side effects in human
newborns, but problems with some drugs in this group have been reported in animal studies.\textsuperscript{35}

38. Of the SSRIs, sertraline (Zoloft) and paroxetine (Paxil) have very low levels in breast milk.\textsuperscript{35} Most tricyclics seem to be safe, but their use is limited by maternal side effects. As in most treatment decisions, the benefits need to be weighed against the risks, and women and their partners must be included in the decision whether to expose their infants to an antidepressant drug. Breastfeeding may be a critical concern for mothers experiencing postpartum depression: Some feel they have failed as mothers if they must stop breastfeeding and some are frightened by potential damage to the infant. Other women are relieved to receive permission to stop breastfeeding so they can take antidepressants without worrying about possible long-term effects on their children. Moderate to severe depression must be treated because of the major impact on the baby. If a mother is reluctant to take medication, it may be helpful to explain that depression itself is detrimental to the baby.\textsuperscript{30} Ultimately, the mother must be the one to make the decision about medication, and therefore she must receive all the information she needs to make an informed choice.
Case 1: Maria, aged 22

Maria is suffering from postpartum blues. Unlike postpartum depression, her symptoms are mild, occurring within the first two weeks after delivery.

- **How will you ask Maria about how she is feeling?**

The FP must ask the mother four key questions at this point:
- Are you eating?
- Are you sleeping?
- Are you getting out?
- Are you having any scary thoughts about yourself or your baby?

- **How will you respond to John’s question?**

Maria and John’s baby has lost less than 10% of birth weight in the first week. This is common and you can reassure Maria and John that nothing is wrong with their child. A worthwhile discussion would focus on Maria’s breastfeeding technique and timing, and the possible involvement of a lactation consultant or breastfeeding clinic.

At this point, the FP can provide education and reassurance to John about the nature of postpartum depression, combined with an assessment of the baby’s crying. The FP is in a good position to monitor the family’s overall adjustment and mental health: Referral to a psychiatrist or a social worker usually is not indicated at this time.

- **What additional information would you want to obtain?**

Remember the importance of asking about
- a personal or family history of depression (particularly postpartum depression).
- the current social support network.
- life stressors (e.g., financial problems, abuse).

All these are risk factors for postpartum mood disorders.

- **How would you manage this situation to help Maria and her family?**

Early follow-up care within one week after birth is important to check the baby’s weight and the mother’s mental health. Mothers need reassurance and confirmation that they and their baby are progressing well. Involvement of fathers or other partners is very important at this point, both to educate them about the importance of keeping a close watch on their partners’ progress, and as a source of information for the physician and health care team.

Suggestions about how family members and friends can be supportive may be helpful. These suggestions could be part of the prenatal plan (e.g., no visitors
for the first few days, and then only those bringing food or a vacuum cleaner). See Table 3 for more discussion topics.

**Case 2: Renée, aged 30**

Renée is showing signs of postpartum depression—anxiety, insomnia, and frequent crying. She also has a positive family history of depression in her mother.

- **How will you respond to Renée’s concern? What question(s) will you ask next?**

The FP should ask four questions:

- Are you eating?
- Are you sleeping?
- Are you getting out?
- Are you having any scary thoughts about yourself or your baby?

If postpartum depression is present, the patient will often experience tears by the second question. The NICE Guidelines in Table 2 and/or the Edinburgh Postnatal Depression Scale in Appendix 1 can be used to gain a more complete understanding of the level and nature of her symptoms. At a minimum, the plan should include supportive psychotherapy, social and even practical support (e.g., help with caring for the baby or with other tasks), if necessary. If individual or postpartum group psychotherapy is available, a referral is indicated. Antidepressant medication is likely indicated. The family should be involved in the development of the plan, or a problem with adherence to it may arise. The father or other partner and any other supportive family members need to be educated about the risks of postpartum depression and the need for close monitoring with Renée. She does not need to be hospitalized at this point, but initiating a referral for psychiatric consultation may be worthwhile.

- **What does Renée’s inability to sleep reveal to you? What should you check for next?**

- **How will you respond to Renée’s disclosure about her mother’s episode of postpartum depression?**

Renée’s insomnia may indicate an evolving diagnosis of anxiety or depression.

Postpartum depression may be inherited genetically. Mothers with a first-degree relative (mother or sister) who had postpartum depression may be at higher risk than the general population.

One of the most common questions that women ask when they recover from postpartum depression is how to prevent depression in subsequent pregnancies (during which these women will be at increased risk). In such cases, pre-pregnancy planning is ideal, as it helps women with decisions about preventive therapeutic interventions, whether or not to continue antidepressant drugs during pregnancy, and maximizing postpartum sleep and social support.
Case 3: Bridget, aged 25

- What is the probable diagnosis?

Bridget is showing signs of postpartum psychosis and needs urgent psychiatric assessment and, probably, psychiatric hospitalization (see information points 30 to 33). Her previous psychiatric illness was likely a psychotic episode, possibly a manifestation of mania, psychotic depression, or schizophrenia.

- What can you say and do at this point?
- What is the next step if you determine Bridget has postpartum psychosis?

Bridget needs to be informed that she has a serious mental illness and requires hospitalization and sedative medication (e.g., a benzodiazepine with or without an antipsychotic) immediately to reduce her agitation. She may have to be certified for mandatory admission, and may need security or police to escort her from your office to the hospital emergency department. Some hospitals can accommodate mothers and their babies during admission for depression. Depending on her eventual diagnosis, Bridget will likely require ongoing lifelong treatment with psychotropic medication.


RESOURCES

1. Books for Patients


Dalfen A. When baby brings the blues: solutions for postpartum depression. Mississauga, ON: Wiley and Sons; 2009.


Kleiman KR. Therapy and the postpartum woman: notes on healing postpartum depression for clinicians and the women who seek their help. New York: Routledge; 2009.


2. Websites


3. Videos


From pregnancy to parenthood: facilitating postpartum adjustment (1994). Working With Families Institute, Department of Family & Community Medicine, University of Toronto, Toronto, ON.


4. Ontario-specific Resources (current as of April 2011)


Good Beginnings Program (volunteer support for parents with infants from birth to age six months): 905-479-3701, ext 5137 or 5124.

Peel Postpartum Family Support Line (emotional support; lines open Monday to Friday, 10 am to 10 pm): 905-459-8441.


Toronto York Region VON (nursing and homemaking services): 905-479-3201.
APPENDIX 1

Introduction to the Edinburgh Postnatal Depression Scale (EPDS)

The EPDS was developed to help primary care health professionals detect mothers suffering from postpartum depression. In one Australian study, a score of 12.5 or more was shown to indicate major depression with a sensitivity of 100% and a specificity of 95.5%.[24] The scale consists of 10 short statements with four possible responses. The mother underlines the one that is the closest to how she has been feeling over the past week. Most mothers can complete the scale in less than five minutes in the waiting room. With some practice, the instrument can be scored quickly and a woman who meets a threshold score (over 10 recommended for primary care) can be assessed further. Asking a woman to answer questions about how she is feeling not only causes her to stop to think about herself, but also indicates her physician’s willingness to hear about her psychological distress.[16] It should not take the place of clinical judgment and in doubtful cases, should be repeated after two weeks. The scale will not detect mothers with anxiety neuroses, phobias, or personality disorders.

Instructions for users:[24]

1. The mother is asked to underline the response that comes closest to how she has been feeling for the previous seven days.
2. All 10 items must be completed.
3. Care should be taken to avoid the possibility of the mother discussing her answers with others.
4. The mother should complete the scale herself, unless she has limited English or has difficulty with reading. In these cases, a non-family member should translate, if possible.
5. The EPDS may be used at six to eight weeks postpartum for screening. The family practice office visit or well-baby checkup may provide a suitable opportunity for its completion. The tool also provides the mother with tangible evidence of improvement in her symptoms.
Edinburgh Postpartum Depression Scale\textsuperscript{24}

In the past seven days:
1. I have been able to laugh and see the funny side of things
   □ As much as I always could
   □ Not quite so much now
   □ Definitely not so much now
   □ Not at all

2. I have looked forward with enjoyment to things
   □ As much as I ever did
   □ Rather less than I used to
   □ Definitely not so much now
   □ Hardly at all

3. I have blamed myself unnecessarily when things went wrong*  
   □ Yes, most of the time
   □ Yes, some of the time
   □ Not very often
   □ No, never

4. I have been anxious or worried for no good reason
   □ No, not at all
   □ Hardly ever
   □ Yes, sometimes
   □ Yes, very often

5. I have felt scared or panicky for no very good reason*  
   □ Yes, quite a lot
   □ Yes, sometimes
   □ No, not much
   □ No, not at all
6. Things have been getting on top of me*
   - Yes, most of the time I haven't been able to cope at all
   - Yes, sometimes I haven't been coping as well as usual
   - No, most of the time, I have coped quite well
   - No, I have been coping as well as ever

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

8. I have felt sad or miserable*
   - Yes, most of the time
   - Yes, quite often
   - Only occasionally
   - No, never

9. I have been so unhappy that I have been crying*
   - Yes, most of the time
   - Yes, quite often
   - Only occasionally
   - No, never

10. The thought of harming myself has occurred to me*
    - Yes, quite often
    - Sometimes
    - Hardly ever
    - Never

Response categories are scored 0, 1, 2, 3, according to increased severity of the symptom.

*These items are reverse scored (i.e., 3, 2, 1, 0).

The total score is calculated by adding together the scores for each of the 10 items.
APPENDIX 2

DSM-IV criteria for a major depressive episode

At least five of the following symptoms will have been present for a two-week period. One of the symptoms will be depressed mood or loss of interest or pleasure nearly every day.

1. Depressed mood most of the day
2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day
3. Significant weight loss or weight gain when not dieting, or decrease or increase in appetite
4. Insomnia or hypersomnia
5. Psychomotor agitation or retardation
6. Fatigue or loss of energy
7. Feelings of worthlessness or excessive or inappropriate guilt
8. Diminished ability to think or concentrate
9. Recurrent thoughts of death, recurrent suicidal ideation without a specific plan, or suicide attempt

The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. They are not due to the direct effects of a substance or general medical condition, and they do not occur within two months of the loss of a loved one. In severe cases, these symptoms may be accompanied by psychosis (bizarre or paranoid thoughts).

Note: Minor depression is characterized by two weeks of depressed mood and fewer than five symptoms.