

It's Not Just Postpartum, and It's Not Just Depression

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This information was originally developed as a free continuing education (CE) activity for primary care, obstetric, and pediatric healthcare providers. Accreditation for this activity has expired, however it is still available as a learning tool.

The following cases are modeled on the interactive grand rounds approach. The in-content and post-content questions and answers have been removed because the CE activity is no longer accredited.

Case 1: Presentation

Lisa is a 32-year-old healthy white woman visiting the nurse practitioner (NP) at her obstetrician/gynecologist (OB/GYN) office for a routine checkup during the first trimester of her first pregnancy.

On her patient history form, she checks "yes" for asthma and a psychiatric disorder but "no" for all other conditions. She notes that her psychiatric condition was a brief episode of mild depression about 6 years ago.

Lisa takes a daily prenatal vitamin but no routine medications or supplements. She does not drink or smoke. She was using birth control pills but stopped taking them 6 months ago to start a family. After reviewing Lisa's history, the NP decides Lisa has an increased risk of perinatal depression and/or anxiety.



Perinatal Depression and Anxiety

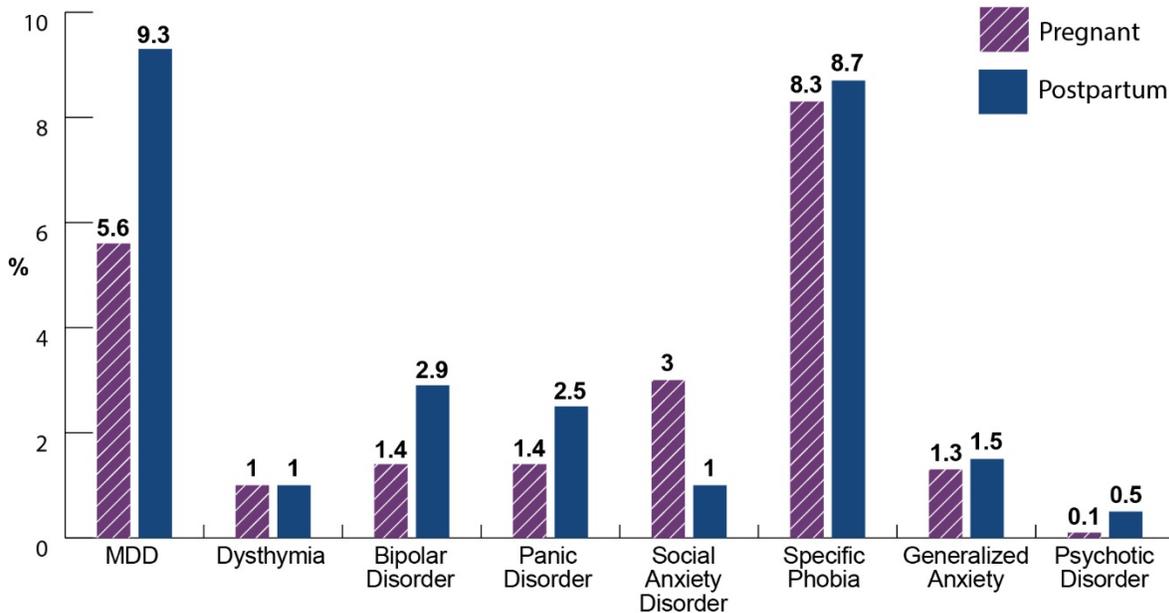
What is often referred to as postpartum depression (PPD) is being expanded in practice to include depression and anxiety disorders that arise during pregnancy or in the first 12 months after childbirth. Untreated perinatal depression and anxiety can have significant implications for women and their children. This case-based activity addresses key points for assessing pregnant women and women who have recently given birth for their risk of perinatal depression and anxiety and for discussing perinatal depression and anxiety risk factors and symptoms with patients and their loved ones.

Epidemiology of Perinatal Depression and Anxiety Disorders

The American Psychiatric Association published an updated edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-V) in 2013 that reflects the growing appreciation of perinatal depression and/or anxiety as more than a postpartum condition and more than just depression. For example, one-half of postpartum major depressive episodes (MDEs) begin before delivery.³ The DSM-V defines "depressive disorders with peripartum onset" as a current or prior MDE with mood symptoms that occur during pregnancy or within 4 weeks after delivery. Although the DSM-V specifies postpartum onset as within 4 weeks after pregnancy, it notes that an MDE may arise months after delivery.³ This description is consistent with clinical practice, which generally considers perinatal depression to be the occurrence of any major or minor depressive episodes during pregnancy or in the first 12 months after delivery.⁴ The DSM-V also notes that severe anxiety and panic attacks often accompany a peripartum MDE.³

Perinatal depression and anxiety are common complications of pregnancy. The 2001-2002 National Epidemiologic Survey on Alcohol and Related Conditions surveyed pregnant and postpartum U.S. women for new onset of a psychiatric disorder within the previous year using DSM-IV criteria (Figure 1). In the postpartum population, 15 percent had a mood disorder and 12 percent had an anxiety disorder.⁵ Among pregnant women, 9 percent had a mood disorder and 12 percent had an anxiety disorder.⁵ However, depression and anxiety are frequently overlooked in pregnant women, and actual rates may be higher.

Figure 1. 12-Month (from 2001 to 2002) Prevalence of Psychiatric Disorders in U.S. Pregnant and Postpartum Women as defined in DSM-IV⁵ (MDD = Major Depressive Disorder)



Looking specifically at depression, a Centers for Disease Control and Prevention (CDC) survey of reproductive-aged women found that 8 percent of pregnant women had experienced a MDE in the past year.⁶ In addition, an analysis of data from 17 states enrolled in the Pregnancy Risk Assessment Monitoring System (PRAMS) found that 12 percent to 20 percent of postpartum mothers reported symptoms consistent with PPD.⁷

Risk of depression during the perinatal period is even higher for women with disabilities and immigrant women. In a study that surveyed women with disabilities, 25 percent said they received a depression diagnosis during pregnancy and 30 percent said they had PPD symptoms.⁸ A meta-analysis of studies that included almost 14,000 immigrant women found that 20 percent experienced symptoms of PPD.⁹ Analyses of perinatal depression by race or ethnicity are inconsistent, with some studies finding higher rates among white women and others finding higher rates among minority groups.^{2,10}

A review of studies examining anxiety disorders in pregnancy found that the prevalence of any anxiety disorder during pregnancy varies widely among studies, ranging from 4 percent to 39 percent.¹¹ Depression and anxiety commonly occur together, with one study showing that approximately two-thirds of women with perinatal depression had an anxiety disorder.¹²

Pathophysiology of Perinatal Depression and Anxiety

The pathophysiology of perinatal depression and/or anxiety remains unclear. Research has implicated hormonal changes, immune or inflammatory processes, genetic and epigenetic changes, and psychosocial factors such as stress or problems with interpersonal relationships.¹³ Although data concerning biological causes of perinatal depression and/or anxiety are inconclusive, studies have identified various psychological and social risk factors. A history of mental illness (especially a history of anxiety and depression) and perceived lack of partner support are the strongest risk factors for antenatal depression.² One-half of pregnant women who had a previous MDE develop perinatal depression, underscoring the importance of obtaining a thorough psychiatric history.² Other risk factors for antenatal depression or anxiety include increased life stress; inadequate social support; a history of child abuse; prior or current domestic violence or emotional, physical, or sexual abuse; a family history of psychiatric illness; and pregnancy during adolescence.^{1,2,14} Findings are inconsistent as to whether socioeconomic status, smoking, alcohol use, older age, and obstetric factors influence a women's risk of antenatal depression.^{1,2}

The same factors that increase the risk of antenatal depression and anxiety increase the risk of PPD and anxiety. In addition, antenatal depression and anxiety are independent predictors of PPD.¹⁵ However, complications during pregnancy or delivery and low socioeconomic status were characterized as small risk factors.¹⁵ Some evidence associates pregnancy during adolescence with PPD, with one study estimating the rate of PPD in teen mothers as 53 percent to 61 percent.¹⁶ Having a difficult or unhealthy infant or difficulty with breastfeeding may also increase risk.^{4,17}

Patient and Partner Education in Preventing, Identifying, and Reporting Perinatal Depression and Anxiety

A CDC-led study found that 66 percent of women retrospectively identified as having a major depressive disorder (MDD) while pregnant never received a diagnosis.⁶ Many cases of perinatal depression and/or anxiety go undetected because women are reluctant to mention mood changes to providers or loved ones and many providers do not ask.

More than 30,000 women from 23 states and New York City who took part in the PRAMS were asked, "During any of your prenatal care visits, did a doctor, nurse, or other healthcare worker talk with you about what to do if you feel depressed during your pregnancy or after your baby is born?"²¹ Approximately three-fourths of women answered "yes." However, the percentages varied from state to state, from 61 percent in New York City to 86 percent in Maine. Overall, about one-third of women who screened positive for postpartum depressive symptoms had never discussed perinatal depression with their provider.²¹

There are states that now require professionals who provide prenatal care to educate women about perinatal depression and anxiety. Discussing perinatal depression and anxiety with pregnant women and their partners can help the pregnant women

recognize symptoms and understand the importance of reporting symptoms to their provider. As observed in the New York City PRAMS study, women who discussed depressive symptoms with their providers were much more likely to receive a diagnosis than were women who did not discuss depressive symptoms.¹⁰ Prompt diagnosis and treatment may relieve the burden of depressive symptoms and prevent progression to perinatal depression and/or anxiety in some cases, especially in women with risk factors.

In a meta-analysis of 37 randomized controlled trials of preventive interventions, Sockol and colleagues found a 27-percent reduction in the prevalence of depressive episodes and a reduction in levels of depressive symptoms at 6 months postpartum in women who received any intervention.¹⁸ A meta-analysis of trials that evaluated psychosocial and psychological interventions found the interventions significantly reduced PPD risk.²⁰ Professionally based postpartum home visits, phone-based peer support, and interpersonal psychotherapy were especially promising interventions.²⁰

Howell, et al, evaluated a 2-step educational intervention to help mothers manage modifiable risk factors for PPD.¹⁹ A social worker met with mothers in the hospital after delivery and reviewed a pamphlet that discussed the normalcy of depressive symptoms postpartum, realistic expectations for childbirth recovery, and management of stressful situations that new mothers often encounter.^{19,22} Patients' partners received a handout summarizing depressive symptoms, warning signs, and ways to help. Both handouts stressed the importance of social support. The social worker called the mothers 2 weeks later to discuss symptoms and their management efforts.^{19,22} Screening of black and Hispanic mothers over the next 6 months showed that those mothers in the intervention group were less likely than those mothers in the control group to develop PPD¹⁹; in a cohort of mostly white mothers, no difference in risk of PPD was observed between mothers who received the intervention and those mothers who did not.²²

Perceived lack of partner support is a strong risk factor for perinatal depression and/or anxiety.^{2,23,24} Emerging evidence suggests that enhancing partner support through interventions that improve communication and relationship satisfaction may be a promising strategy for reducing the risk of perinatal depression and/or anxiety.²³ Results have been mixed from randomized controlled trials that analyzed the efficacy of cognitive-behavioral therapy (CBT), antenatal and postnatal classes, online interventions, and biologic agents in preventing PPD.^{25,26} More studies are needed to compare the efficacies of different preventive interventions and to determine whether interventions earlier in the pregnancy reduce the risk of perinatal depression and/or anxiety.

Case 1: Continued

The NP reviews symptoms of perinatal depression and/or anxiety with Lisa and gives her pamphlets to share with her husband. The NP explains how early recognition of symptoms and treatment improve outcomes and discusses interventions that could reduce Lisa's risk of depression and anxiety.

At later routine pregnancy appointments, the NP checks with Lisa about symptoms of depression and anxiety. At a routine visit near the end of Lisa's second trimester, the OB/GYN in the practice asks Lisa how she is sleeping and eating. Lisa says she eats fairly healthy food, except for adding an ice cream snack before bedtime. She says she sleeps only a few hours each night because her mind is racing. The physician asks about Lisa's mood. Lisa's husband mentions she's been "tearful" for the past few weeks. Lisa admits everything annoys her lately. She notes that she has cancelled plans with friends and does not want to see anyone.

Lisa's husband adds, "You used to have lunch every Saturday with your friends. I can't remember the last time you did that."

Lisa says, "And sometimes I feel like I'm in a fog. I forget what I was going to say and can't make decisions about simple things. I just don't feel like myself."

Symptoms of Perinatal Depression and Anxiety

The onset, symptoms, and clinical courses of perinatal depression and/or anxiety vary greatly among individuals. Patients may manifest physical symptoms or verbalize feelings or attitudes consistent with perinatal depression and/or anxiety, or both.

Antenatal depressive symptoms include appetite changes, sleep disturbances, crying or weepiness, fatigue, irritability, loss of interest or pleasure in normal activities, and anxiety.¹⁴ Women with PPD may experience persistent sadness, frequent crying, difficulty concentrating or making decisions, memory problems, irritability, fatigue, sleep disturbances, appetite changes, and psychomotor agitation.¹⁴ Many women feel overwhelmed and question their self-worth or parenting ability. Some worry that they do not feel a maternal bond with their fetus or infant.¹⁴ Women with PPD or anxiety may also have somatic symptoms, such as headaches, chest pains, palpitations, dizziness, sweating, numbness, or hyperventilation. Physical symptoms accompanied by intense fear may indicate a panic disorder.¹⁵ Women with perinatal depression and/or anxiety may show little interest in caring for themselves and ignore daily tasks. Affected women may describe a loss of concentration, an enveloping "fogginess," a sense of "going crazy," feeling like a "robot," or "going through the motions" of caring for their infant.¹⁵ Many verbalize excessive worry, loss of pleasure in things they once enjoyed, and feelings of incompetency at being a good parent.²⁷

Up to 75 percent of women develop some depressive symptoms in the immediate days and weeks after delivery, colloquially called "postpartum blues" or the "baby blues."²⁸ The baby blues share some symptoms with perinatal depression and/or anxiety, such as crying, irritability, fatigue, and anxiety,¹⁵ but women with the baby blues are more likely to describe their moods as going up and down.²⁹ Also, the baby blues are typically mild and resolve within 10 to 12 days.^{28,29} Postpartum women whose depressive symptoms persist beyond 10 days should be evaluated for depression and anxiety.¹⁵

The severity of perinatal depression and/or anxiety symptoms varies among patients, and the degree of severity correlates with the range of symptoms that patients

experience. A large retrospective study found that women with moderate to severe symptoms of PPD were more likely to report feeling sad, blame themselves unnecessarily, and have trouble sleeping than did women with mild symptoms. Women with the most severe depressive symptoms had more intense feelings of panic and sadness, cried more often, were more likely to contemplate harming themselves, and were more likely to have symptom onset during pregnancy.³⁰ A pre-pregnancy history of mood and anxiety disorders was also associated with earlier onset of perinatal depression or perinatal anxiety and more severe symptoms.³⁰

Symptoms of perinatal depression and/or anxiety are not always apparent during a healthcare visit. To learn more about possible symptoms, providers should ask patients about their eating and sleeping habits, moods, and worries.⁴ However, changes in sleep or energy are common for new mothers and may not be reliable indicators of PPD and/or anxiety.³ Perinatal women may not recognize their symptoms, and those who do may be embarrassed to admit their thoughts because of the tremendous social stigma associated with not feeling overwhelming joy at the birth of one's baby.²⁷ For these reasons, it is essential to educate partners and family members about the signs of depression and anxiety.²⁷

Postpartum Psychosis and Other Mental Health Disorders

As symptoms of depression or anxiety intensify, a small percentage of women experience abnormal thoughts, which may include recurrent thoughts about harming themselves or the baby.^{14,31} Between 1 and 2 of every 1,000 new mothers develop postpartum psychosis, which is associated with sensory hallucinations, delusions, mania, and suicidal or homicidal thoughts.¹⁴

Women may also have insomnia and exhibit confusion, mood fluctuation, cognitive impairment suggestive of delirium, or bizarre behavior.²⁹ Onset of postpartum psychosis typically occurs within a few days to a few weeks after delivery.¹⁴ Women with prior postpartum mood episodes or a personal or family history of bipolar disorder are especially susceptible to postpartum psychosis.³ The recurrence rate of postpartum psychosis with subsequent deliveries is 30 percent to 50 percent.³ Although postpartum psychosis is uncommon, it is a psychiatric emergency that requires immediate psychiatric evaluation and medical attention.¹⁴ Clinicians should also be aware of the potential for other mental health disorders to emerge or worsen during pregnancy or postpartum.³

For example, a meta-analysis found that approximately 37 percent of women with a history of bipolar disorder had a postpartum relapse³²; the majority of relapses did not involve psychosis or require hospitalization. Evidence also suggests that perinatal women have a greater risk of new-onset obsessive-compulsive disorder (OCD) and that OCD symptoms may worsen in women with preexisting OCD.³³ A study by Miller, et al, found that at 2 weeks postpartum, women with depression were significantly more likely to report OCD symptoms than were women without depression (26 percent vs. 8 percent). This significant association was also evident 6 months later, when 17 percent of women with depression and 8 percent of women without depression

screened positive for OCD symptoms.³⁴ For women with preexisting OCD or bipolar disorder, postpartum planning may be useful to prevent relapse or worsening of symptoms.

Overview of Screening for Perinatal Depression

Systematic screening during pregnancy and postpartum is an effective means of identifying women at risk for perinatal depression.¹⁷ Screening, if followed by appropriate treatment or support, appears to reduce depression symptoms and the overall prevalence of PPD. Also, "evidence suggested that programs to screen pregnant and postpartum women, with or without additional treatment-related supports, reduce the prevalence of depression and increased remission or treatment response."¹⁷

Several groups have published guidelines on screening perinatal women for depression.^{4,35,36} The U.S. Preventative Services Task Force (USPSTF) recently updated its depression guidelines to recommend screening all pregnant and postpartum women based on clinical trials that associated screening programs with a reduction in depression risk in the range of 28 percent to 59 percent.³⁵ The American College of Obstetricians and Gynecologists and the Association of Women's Health, Obstetric, and Neonatal Nurses advise screening all pregnant or postpartum women for depression and anxiety symptoms at least once using a standardized validated instrument.^{4,36}

Any healthcare provider or facility that cares for perinatal women or infants should offer screening for perinatal depression and/or anxiety, including all facilities that offer obstetric, neonatal, pediatric, or comprehensive health care.^{4,36,37} Physicians and nurses who deliver obstetric care have an opportunity to screen patients throughout their pregnancy and at the 6-week postpartum office visit. Given the longitudinal nature of the relationship that pediatricians and pediatric nurses have with families, they should integrate screening into the well-child schedule.³⁸ In-hospital perinatal nurses may want to consider screening new mothers before discharge.³⁹ Primary care providers (PCPs) also have an opportunity to screen new mothers for their risk of perinatal depression and anxiety.

Providers should always use an instrument validated for perinatal depression screening. Several are available, most of which take less than 10 minutes to administer (Table 1).⁴ The USPSTF guidelines consider the Edinburgh Postnatal Depression Scale (EPDS) a reliable tool for perinatal depression screening (no studies of other depression screening instruments in a perinatal population satisfied USPSTF's inclusion criteria).¹⁷

Table 1. Depression Screening Tools ⁴

Tool	Number of Items	Time to Complete (Minutes)	Sensitivity and Specificity	Spanish Version Available
Edinburgh Postnatal Depression Scale (EPDS)	10	Less than 5	Sensitivity 59% to 100% Specificity 49% to 100%	Yes
Postpartum Depression Screening Scale	35	5 to 10	Sensitivity 91% to 94% Specificity 72% to 98%	Yes
Patient Health Questionnaire 9	9	Less than 5	Sensitivity 75% Specificity 90%	Yes
Beck Depression Inventory	21	5 to 10	Sensitivity 47.6% to 82% Specificity 85.9% to 89%	Yes
Beck Depression Inventory-II	21	5 to 10	Sensitivity 56% to 57% Specificity 97% to 100%	Yes
Center for Epidemiologic Studies -- Depression Scale	20	5 to 10	Sensitivity 60% Specificity 92%	Yes
Zung Self-Rating Depression Scale	20	5 to 10	Sensitivity 45% to 89% Specificity 77% to 88%	No

Screening measures the risk of depression or anxiety and is not diagnostic. Providers who screen women for perinatal anxiety and perinatal depression should have plans established to ensure that women whose screening results are positive undergo further

evaluation to receive a diagnosis and management from an appropriate healthcare provider.⁴ Establishing relationships with mental health professionals and social service agencies can assist with referrals and coordinating care. It is critical to follow referred patients to confirm they are receiving appropriate care and their symptoms are improving. Emergency care is recommended for any patient in danger of injuring herself or her infant.³⁶

Case 1: Continued

The OB/GYN screens Lisa using the EPDS. Lisa's score is 13, which points to a high likelihood of depression and the need for further assessment. During the screening, Lisa indicates she has "never" thought of harming herself. The OB/GYN asks additional questions to ensure Lisa is not in immediate danger.

The OB/GYN discusses results of the screening and available treatment options with Lisa and her husband and emphasizes the importance of support from her loved ones. The OB/GYN recommends that Lisa see her PCP or a mental health professional to get a diagnosis and a tailored treatment plan.

Treatment and Other Resources

It is important to assure patients with perinatal depression and/or anxiety that effective treatments are available to help relieve symptoms. CBT and similar approaches are the most-studied treatments for perinatal depression and/or anxiety.¹⁷ The goals of CBT are to help patients modify thinking and behaviors that promote depression.²⁸ Some data suggest acute PPD may require a combination of pharmacological and psychosocial interventions.¹⁵

A Cochrane review examined the efficacy of psychosocial and psychological interventions in treating PPD.⁴⁰ The reviewers considered trials of peer support or nondirective counseling administered via phone or during home and clinic visits and trials of psychological interventions, including CBT and interpersonal therapy.⁴⁰ Overall, both psychosocial and psychological interventions reduced PPD symptoms within the first year.⁴⁰ Insufficient evidence is available to determine which psychosocial or psychological intervention is the most effective.²⁸ Involving a woman's partner in her PPD treatment may also improve outcomes, but there are insufficient data to recommend a specific partner-based intervention.²⁸ Studies on alternative treatments such as acupuncture, massage therapy, bright light therapy, and vitamin or mineral supplementation, suggest that none of them are efficacious for depression and/or anxiety in pregnant or postpartum women.²⁸

It is important to discuss all available treatment options with women at risk for perinatal depression and/or anxiety so they can participate in the decision-making process. Women should also be informed of the risks of not getting treatment. More quality studies comparing treatments for perinatal depression and/or anxiety are needed to facilitate evidence-based management.

Case 1: Continued

The NP follows up with Lisa to see how she is doing and to confirm that she has scheduled the suggested appointment. When Lisa says she has not had time to schedule an appointment, the NP explains the risks of not getting a diagnosis and treatment plan from a mental health professional.

Adverse Maternal Outcomes When Perinatal Depression or Anxiety Is Untreated

Perinatal depression and anxiety typically do not get better without treatment. Despite this, almost one-half of women with diagnosed perinatal depression do not receive treatment.⁴⁴ Untreated perinatal depression and/or anxiety is associated with significant maternal morbidity and mortality.

The most serious maternal risk of untreated depression is suicide, which is a leading cause of death among perinatal women in some industrialized countries.⁴⁵ A U.S. study of 628 mothers with PPD found 21 percent had thought about harming themselves, and of these 132 women, 23 percent thought about harming themselves "sometimes" or "quite often."⁴² A U.K. study found that perinatal suicides were more likely to occur in women with a diagnosis of depression who were not receiving treatment than in those receiving treatment.⁴³ For 50 percent to 60 percent of women with untreated antenatal depression, psychiatric symptoms will worsen and their depression will persist after delivery.⁴¹ Worsening depression compromises quality of life and function.⁴⁶ So it is important to seek treatment to receive an appropriate diagnosis.

Anxiety and depression during pregnancy or postpartum correlate with an increased risk of unhealthy behaviors, such as drinking, alcohol use, and substance abuse.^{41,47-49} Pregnant women with depression are also less likely to follow medical recommendations for pregnancy, such as getting proper nutrition, resting, practicing proper hygiene, and seeking appropriate prenatal care.^{41,48,50} They may be unmotivated to report problems to their provider.⁴¹ Unhealthy behaviors during pregnancy may lead to obstetric complications and poor birth outcomes.^{41,48} One meta-analysis found that having MDD during pregnancy significantly increased the risk of preterm birth and low birth weight, especially in low-income women.⁴⁸

Case 1: Conclusion

Lisa agrees to make an appointment with a mental health provider right away. After a clinical evaluation, her psychiatrist determines she has MDE with peripartum onset. They discuss treatment options, and she agrees to try CBT and to get peer support from a mother who went through perinatal depression and/or anxiety.

The psychiatrist stresses to Lisa and her husband how important it is to make sure Lisa has support. He also emphasizes the need to seek urgent medical care if Lisa has any

thoughts of self-harm. Lisa visits the psychiatrist for monitoring for the rest of her pregnancy, and her symptoms start to improve.

The NP calls Lisa to see how she is doing and to ask whether she has consulted a mental health professional.

Case 2: Presentation

Tonya is a 26-year-old single mother who brings her son Ryan to the pediatrician's office for his 2-month vaccinations. Tonya's mother accompanies her and, when Tonya briefly leaves the examination room, her mother confides to Jessica, the pediatric nurse, that she is worried about Tonya.

"I didn't want to say this in front of her, but she's not herself lately. She feeds Ryan and changes him, but it's like she's just going through the motions. She doesn't really look at him or talk to him and always asks me to hold him," Tonya's mother says.

Jessica asks how long Tonya has been like this. "Since Ryan was born, but it's getting worse." Jessica asks if she's talked to Tonya about it, and her mother says "no," that's she is afraid of upsetting her.



Jessica then tells Tonya's mother how important her support is right now and offers to mention her concerns to the pediatrician, Dr. Simon.

Supporting New Mothers Who Have Depression and/or Anxiety Symptoms

"Social support" is defined as the social resources people believe they can access if needed or the actual support they receive from members of their social network.²⁴ Social support can be emotional (e.g., offering encouragement or love), instrumental (e.g., babysitting or helping with tasks), or informational.^{24,55}

An abundance of literature shows that social support plays an important role in treating or protecting against perinatal depression and/or anxiety.^{2,24,52,53,56,57} For example, postpartum women with more social support or larger social networks (2 or more people) experience fewer depressive symptoms than do women with less social support or smaller social networks (1 person or none).⁵⁸ Higher levels of social support enhance new mothers' perceptions of self-efficacy, which correlates with better mental health and a reduced risk of depressive symptoms.^{52,55,59} Social support appears to be especially important for adolescents, minority women, and low-income women transitioning to motherhood.⁶⁰

Women commonly identify their partners and mothers as primary and preferred sources of support.⁵⁷ Partner support has an especially strong effect on PPD; having a supportive partner significantly reduces PPD risk, whereas having a violent partner significantly increases risk.^{24,52} Positive partner support is also associated with a reduced risk of postpartum anxiety.⁵⁹ Mothers who do not live with a partner have more depressive symptoms than do cohabitating mothers.²⁴ Other sources of support include friends, other family members, and professionals, such as counselors or visiting nurses.⁵⁷ Some evidence suggests that women with PPD value support from family and friends more than professional support.⁶¹ Organized religious groups, self-help groups, and peer interventions also provide support.^{54,60} In studies of peer interventions, new mothers perceived a benefit from phone-based and in-home peer support, although peer interventions did not always reduce PPD risk.⁵⁴

In addition to encouraging new mothers to approach partners and family for support, providers should direct friends and family in the mother's support network to resources on how to support the mother. For example, providers could reference or give friends and family the conversation starters card below from the *Eunice Kennedy Shriver* National Institute of Child and Human Development titled, [Talk About Depression and Anxiety During Pregnancy and After Birth: Ways You Can Help](#).⁶²

Talk About Depression and Anxiety During Pregnancy and After Birth: Ways You Can Help

- **Listen.** Open the lines of communication.
 - "I know everyone is focused on the baby, but I want to hear about you."
 - "I notice you are having trouble sleeping, even when the baby sleeps. What's on your mind?"
 - "I know a new baby is stressful, but I'm worried about you. You don't seem like yourself. Tell me how you are feeling."
 - "I really want to know how you're feeling, and I will listen to you."
- **Offer support.** Let her know she is not alone and you are here to help.
 - "Can I watch the baby while you get some rest or go see your friends?" or "How can I help? I can take on more around the house like making meals, cleaning, or going grocery shopping."
 - "I am here for you no matter what. Let's schedule some alone time together, just you and me."
- **Offer to help.** Ask her to let you help her reach out for assistance.
 - "Let's go online and see what kind of information we can find out about this." (Visit <https://nichd.nih.gov/MaternalMentalHealth> to learn more.)

- "Would you like me to make an appointment so you can talk with someone?"

Mothers with depression have a strong desire to talk about their feelings with someone who will listen and understand without judging them.⁶³ In fact, studies show the fear of being judged or criticized or of burdening loved ones inhibits many mothers from seeking support.⁵⁷ Women face other barriers to support, such as an inability to obtain childcare due to cost or trust issues, the unavailability of family or friends, and difficulty maintaining friendships.⁶⁰ Providers should familiarize themselves with community sources of social support for mothers who lack adequate support at home.

Case 2: Continued

Tonya returns as Dr. Simon comes in to examine Ryan. He says Ryan looks healthy and his growth is on target.

"Are you sure he's OK?" Tonya asks. "Because I feel like I'm doing everything wrong." Dr Simon assures her Ryan is fine and asks how she is feeling.

"Sometimes I feel overwhelmed, like I can't handle everything," she admits. She says she wakes up hourly, her mind racing, and is terrified she'll find that Ryan isn't breathing.

Dr Simon tells Tonya it sounds like she is exhibiting symptoms of perinatal depression and/or anxiety.

Communicating with Patients Who Have Symptoms of Perinatal Depression and/or Anxiety

In many countries and cultures, social stigma discourages people with mental health issues like depression from disclosing their symptoms to others.^{31,63} Educating women on perinatal depression has been shown to foster a desire to seek help.⁶³ Providers who interact with new mothers have an opportunity to reduce stigma by reassuring them that they are not alone and that perinatal depression and/or anxiety is a common complication of pregnancy and childbirth.^{38,64} Providers may also want to emphasize that the mother is not to blame, that depressive symptoms do not mean she is "unfit" or a "bad parent," and that she will get better.^{38,64}

In interviews of U.S. and Australian mothers who sought help for perinatal depression and/or anxiety, some respondents described having negative perceptions of their initial discussion of depression with a provider.⁶³ They said the physician was disinterested or patronizing, which enhanced their feelings of guilt or low self-worth. Some women felt the provider did not take their concerns seriously or appeared rushed.⁶³ Listening empathetically and patiently to depressed mothers' concerns can improve their comfort level and enhance their willingness to seek necessary care.⁶³

Case 2: Continued

Dr Simon tells Tonya, "A lot of new moms get depression or anxiety after having a baby, and I think that's what you might be experiencing."

He patiently listens to her explain more about her feelings and reassures her that she is not a bad mother and that there are treatments that can help if she does have perinatal depression and/or anxiety.

Barriers to Screening for PPD

A combination of patient and provider barriers prevents women with PPD from seeking care. Personal barriers, in addition to the social stigma of mental illness, include a desire to avoid being judged as "crazy" or "unfit."⁶⁴ Many mothers feel ashamed for being depressed when society expects them to feel joy, or they feel guilty for not sensing a strong bond with their infant.³¹ They may distance themselves from friends and family rather than share the feelings they are experiencing.³¹ Lack of self-confidence in their parenting skills amplifies their fear of losing custody, which studies have shown is a reason depressed mothers may not seek help.⁶³ The fear of having their children taken away is especially prevalent among lower-income mothers.^{65,66} Cultural issues or language barriers make it difficult for some women to discuss depression with a healthcare professional.⁶³

Barriers to PPD screening cited by providers include time constraints, inadequate training or knowledge to screen, and fear of liability.⁶⁷ Surveys show pediatricians are the most likely provider group to cite inadequate training as a barrier to screening, which suggests the need for interventions to improve their knowledge and confidence.^{38,67} Despite these barriers, most pediatricians, OB/GYNs, and PCPs believe they have a responsibility to identify PPD.^{38,67}

Pediatricians and pediatric nurses have more frequent contact with new mothers than do other providers,⁶⁷ and routinely screening mothers for PPD during initial well-child visits could vastly improve detection rates. Pediatric providers are concerned with the welfare of their patient, which is the infant, and this justifies involving them in screening mothers for PPD.³⁸ However, one focus group found new mothers were reluctant to speak with pediatricians about parenting stress.⁶⁶ The women indicated they would be more likely to talk about their own issues if the pediatrician initiated the conversation and there was trust and continuity of care.⁶⁶

The American Academy of Pediatrics recommends that pediatricians work with OB/GYNs to arrange prenatal visits, which allows the pediatrician to get to know the parent and to learn about any high-risk conditions, such as depression or anxiety.³⁸ The knowledge could help the pediatrician "plan for support and follow-up of the mother-infant relationship."³⁸

Barriers to getting women to follow through with referrals include women's reluctance to accept that their symptoms are serious enough to warrant treatment and a lack of confidence in the effectiveness of treatment.⁶⁸ Efforts to minimize inconvenience, such as referring women to onsite or nearby providers, being proactive about arranging referrals, and ensuring referred providers are included in the patient's healthcare plan, may reduce practical barriers women face.⁶⁸

Case 2: Continued

Dr. Simon offers to screen Tonya with the EPDS. Her score is 15, indicating a high risk of PPD, but her answers show she has no thoughts of self-harm.

Dr. Simon tells her she has symptoms of depression and anxiety and he wants her to visit her OB/GYN or PCP as soon as possible for further evaluation and to discuss treatment. He explains that not getting help could negatively affect her health and Ryan's health.

Adverse Effects of Maternal Depression and/or Anxiety on Children

Untreated perinatal depression and/or anxiety negatively affects mother-infant bonding and can have short- and long-term adverse effects on children.⁶⁹⁻⁷² Rossen, et al, associated higher levels of depression and stress during pregnancy with a weaker mother-infant bond at 8 weeks postpartum.⁷¹ PPD is also associated with impairment of mother-infant bonding.³⁸ As a result, women with PPD are less responsive and less engaged, display less warmth, and are more irritable toward their infants.^{28,72} They also touch and speak to them with less affection and play with them less.⁷²

In the short term, a large prospective cohort study found that mothers with PPD were less likely to ensure their children received proper health care during the first 3 years of life.⁷³ Children whose mothers were depressed at 2- to 4-months postpartum had more acute emergency department visits and fewer preventive care visits and were less likely to be up-to-date on vaccinations.⁷³ Other studies have found that mothers with depressive symptoms are less likely to adopt safety practices to protect their young children from injury, such as consistently using car seats.^{74,75} New mothers with a higher prevalence of depressive symptoms are also less likely to breastfeed, more likely to have difficulty breastfeeding, and more likely to discontinue breastfeeding than are women without PPD.^{28,76}

The long-term effects of PPD on cognition in children are less clear. Some studies have detected cognitive impairment and language delays in children of mothers with PPD,⁷² whereas other studies have found no relationship between PPD and cognitive ability.¹⁵ Authors of a recent systematic review concluded that perinatal distress (primarily depression, anxiety, or stress) did have small to moderate effects on global, behavioral, cognitive/language, and socioeconomic development in school-aged children.⁷⁷

Case 2: Conclusion

Dr. Simon shares information about PPD and anxiety and available treatments. He says he would be glad to talk with her about medication and breastfeeding if her physician recommends drug therapy. Tonya agrees to see her OB/GYN, and Tonya's mother offers to help schedule the visit. Dr Simon asks Tonya to return in 2 weeks for a follow-up visit.

During the follow-up visit, Tonya tells Dr Simon that the OB/GYN agreed she has symptoms of depression and referred her to a mental health provider. She adds that her mother is staying with her during the day and watches Ryan while she attends a support group for mothers with perinatal depression and goes to counseling. At the 4-month visit, she notes that her symptoms are starting to improve.

Abbreviations

CBT = Cognitive-behavioral therapy

CDC = Centers for Disease Control and Prevention

DSM-IV or DSM-V = Diagnostic and Statistical Manual of Mental Disorders, 4th edition or 5th Edition

EPDS = Edinburgh Postnatal Depression Scale

MDD = Major depressive disorder

MDE = Major depressive episode

NP = Nurse practitioner

OB/GYN = Obstetrician/gynecologist

OCD = Obsessive-compulsive disorder

PCP = Primary care provider

PPD = Postpartum depression

PRAMS = Pregnancy Risk Assessment Monitoring System

USPSTF = U.S. Preventive Services Task Force

Additional Resources

[Moms' Mental Health Matters Initiative](#) on Perinatal Depression and Anxiety: [View and order free educational materials](#) developed by the *Eunice Kennedy Shriver* National Institute of Child Health and Human Development (NICHD) as part of your outreach efforts to your community.

[LactMed](#): The LactMed database contains information on drugs and other chemicals to which breastfeeding mothers may be exposed.

[Postpartum Support International \(PSI\)](#): PSI works to increase awareness among public and professional communities about the emotional changes that women experience during pregnancy and postpartum.

[National Institute of Mental Health \(NIMH\)](#): NIMH, a component of the National Institutes of Health and the lead federal agency for research on mental health disorders, is dedicated to understanding, treating, and preventing mental illnesses through basic and clinical research on the brain and behavior.

Substance Abuse and Mental Health Services Administration (SAMHSA): Women can call SAMHSA's [National Helpline](#) at 1-800-662-HELP (4357) for 24-hour free and confidential mental health information and for referrals to treatment and recovery services in English and Spanish.

[Postpartum Progress®](#): Postpartum Progress is a blog and nonprofit organization that raises awareness, fights stigma, and provides peer support to women with maternal mental illness.

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