The Different Faces of PPD and Anxiety

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During their childbearing years, women are at a high risk for their first major depressive episode. The consequences of depression during the post-partum period are considerably more deleterious than at other times because a woman faces the added responsibility of caring for her newborn infant. The demands of infant care alone are new and require adjustment time.

During the post-partum period (up to one year after the birth of a child) a woman can experience a range of mental health symptoms and disorders. These include normal, transient "blues," post-partum depression (PPD) disorder and rare post-partum psychosis.

Post-partum blues

Within two to five days of giving birth, about 50% to 80% of women will experience post-partum blues which subside within a week. Symptoms often peak at five days of post-partum and usually last no more than two weeks and remit without treatment. The blues are a normal and relatively mild physiological condition that can present with lability of mood, crying spells and increased sensitivity. Between 10% and 15% of women who experience transient post-partum blues or "maternity blues" will experience major depression in the first post-partum year.

PPD

Depression is the most common disease in women of childbearing age (15 to 44-years-of-age) worldwide. The association between childbirth and mental illness was recognized officially as a psychiatric disorder with the first refererence appearing in the 1994 edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM IV)*. The *DSM IV* and *DSM IV-Text Revision (TR)* define PPD as a major depressive episode that starts within four weeks post-partum. However, most researchers and clinicians who work with this population recognize that the onset of PPD can occur later. Perinatal depression, including depression in the post-partum period, is a continuum of depressive symptoms and diagnoses that occur up to one year after childbirth. Within the first year of giving birth, between 10% and 28% of mothers suffer from PPD or anxiety.

Between 2003 and 2004, the number of post-partum women who received physician-provided mental health services for their depression within the five health authorities for British Columbia ranged from 8% for Vancouver Coastal to 16% for Vancouver Island. It is estimated that at least 50% of cases start by three months post-partum and 75% by six months post-partum.

Post-partum psychosis

Post-partum psychosis or puerperal psychosis, an episode of mania or psychosis precipitated by childbirth, follows approximately one in 1,000 deliveries. It involves an underlying depression complicated by superimposed psychotic thoughts. In extreme cases, untreated psychotic depression can result in tragedy, such as suicide or infanticide.

The delusions that accompany psychotic depression in the post-partum period frequently involve the infant, thus increasing the possibility of harm to the infant. Psychotic depression in the post-partum period occurs rarely and is a medical emergency that requires immediate hospitalization and treatment with antipsychotic mediations.

Spotlight on PPD

Recognition of the risk factors and common presentations improves early detection. When this leads to timely and appropriate treatment, there is a better chance for a healthy outcome for the woman, baby and family.

Core symptoms of depression and anxiety

The *DSM IV-TR* defines PPD as a mood disorder. However, PPD almost always occurs with comorbid anxiety symptoms. This most often involves exacerbation of pre-existing panic disorder or obsessive compulsive disorder. From a clinical counselling perspective, symptoms of anxiety are often more prevalent than symptoms of depression. Put simply, PPD is a depression that begins after the birth of a baby, often with anxiety symptoms. Whether or not a depression or anxiety begins after the birth of a child, the core symptoms are the same:

- Always tired, worried, anxious
- Increased crying and irritability
- Numbness, guilt or uncharacteristic lack of caring about others
- Inability to concentrate, rest or sleep properly
- Overwhelming sense of loss or burden
- Fear of being alone
- Mood swings (irritability, anger)
- Hopelessness or sadness
- Suicidal or afraid of dying

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Screening and diagnosis

Patient-rated scales (screening)

Screening for depression can improve outcomes when coupled with appropriate treatment and follow-up. The Edinburgh Postnatal Depression Scale (EPDS) is a simple and quick patient-rated scale that can help provide early identification of women who need further assessment and support. The EPDS has the benefit of offering women immediate reassurance about depression, suicidal thoughts and other feelings they may be reluctant to discuss.

Depression severity

Depression in pregnant women can be categorized as mild, moderate or severe. Table 1 can be used as a guideline for determining depression severity.

DSM IV diagnosis and PPD

Prior to diagnosis, it is critical that a proper clinical interview is conducted with the patient in light of *DSM IV-TR* criteria for major depressive episodes, post-partum onset (Table 2).

Table 1

Continuum of depressive symptom severity

Mild	Moderate	Severe
• Vague feelings of guilt and distraction, but able to perform • Transient suicidal thoughts • Sadness/dislike not in response to events, but can participate in activities • Hostile towards others • Slow movement • Social sluggishness • Transient disruption of sleeping, appetite, eating, elimination, or sexual interest • Fatigue related to tasks	• Ruminations about death, failure and hopelessness • Organized suicidal ideas (having plan and method) • Short attention • Feelings that there is little good about self and hostile towards others who enjoy themselves • Slow responses • Noticeable withdrawal from others • Erractic patterns of sleeping, eating, elimination, or sexual function • Consistent fatigue even in the absence of sleep disruption	• Delusion causing catastrophies • Being consumed with depressive thoughts • Profound suicidal ideas that are unimpeded by other thoughts • Absent pleasure • Hatred of self • Unable to perform roles • Broken sleep and no rest gained from sleep • Withdrawal from interacting with others • Noticable weight loss • Severe constipation

Adapted from Suppaseemanont W: Depression in pregnancy: Drug safety and nursing management. Am J Matern Child Nurs 2006; 31(1):10-5.

PPD symptoms

Table 3 sets out PPD symptoms as they present during the post-partum period.

Adjustment factors

From the clinical counselling perspective, there is a distinct group of women who present with PPD where adjustment disorders are more prevalent than mood or anxiety disorders. In the *DSM IV-TR*, symptoms or behaviours related to an adjustment disorder occur within three months of stressor onset and are clinically significant when either of the following is present:

- Marked distress that is in excess of what would be expected from exposure to this stressor
- Significant impairment in social or occupational (academic) functioning

Adjustment disorders are coded with depression, anxiety, or conduct symptoms.

During the post-partum period, adjustment disorders tend to present among two subgroups at opposite poles along a continuum of childbearing age.

First, very young and typically first-time mothers often present PPD with an adjustment disorder when they are not ready to trade their new-found independence for broad parental and personal responsibilities.

The second group comprises older, more established women. The "capacity to adjust" is a core factor among those least likely to develop post-partum issues. Thus, well educated and financially stable women are seen to have greater immunity against depression. Still, these women can and do develop PPD and can be more at risk of going undetected and untreated.

The so-called successful, educated and working woman tends to have an established sense of self, along with perfectionistic tendencies and high expectations of themselves. In life, they are familiar with the experience of receiving various rewards for their efforts and hard work. It can be a shock when their endless hard work (during pregnancy) is followed by an infant who cries frequently, a bottomless hamper full of dirty clothes, an infected

Table 2

***DSM IV-TR* criteria for major depressive episodes, post-partum onset**

Five or more of the following symptoms (Column 1) must be present daily, or almost daily for at least two consecutive weeks:

- Depressed mood*
- Loss of interest or pleasure in various activities*
- Significant increases or decreases in appetite
- Insomnia or hypersomnia
- Psychomotor agitation or retardation
- Fatigue or loss of energy
- Feelings of worthlessness or guilt
- Diminished concentration
- Recurrent thoughts of suicide or death

The symptoms:

- Do not meet the criteria for other psychiatric conditions
- Cause significant impairment in usual functioning at work, school and in social activities
- Are not due to the direct efforts of a substance or general medical condition
- Are not better accounted for by bereavement due to the loss of a loved one

* At least one of those symptoms must be in first or second place.

DSM IV-TR: Diagnostic and Statistical Manual of Mental Disorders-Text Revision

Taken from: American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders.* Fourth Edition. Text Revision. American Psychiatric Association, Washington, District of Columbia, 2000.

breast and a partner who comes home to ask what she has done all day because the house is a mess and dinner is not in the oven. For some women, leaving the workforce may mean a shocking loss of identity, independence and sense of success.

The risk is that these women may be deemed "competent" and thus they are reluctant to express their experiences of feeling incompetent, out of control or dissatisfied and wonder how it is possible to think such awful things after bringing a beautiful baby into the world. This presents a challenge for identification and the risks of an untreated disorder at an important and vulnerable time. These women need help to adjust their expectations, shift their measure of success and increase their flexibility in their thinking. The more tolerant and accepting they can be, the more immunity they will have against PPD.

When health professionals attune to a patient exhibiting adjustment challenges during the post-partum period, an exploration with the patient may lead to appropriate treatment, despite a presentation of depression or anxiety that may not be as apparent as in other cases.

When an adjustment disorder presents, regardless of age grouping, the following factors are common:

- Perfectionism
- Loss of financial independence, status and control
- Loss of structure and predictability in daily life
- Struggle and dissatisfaction with activities that are more physical and less enticing (*e.g.*, house cleaning, laundry, long walks with new baby)

PPD risk factors

There are few, if any, differences between the core symptoms for depression and PPD. However, PPD recognition can be more effective when GPs and

Table 3

Presentation of PPD symptoms in the post-partum period

Emotional symptoms	Behavioural symptoms	Physical symptoms
Intrusive thoughts that may include: • Thoughts of harm coming to baby • Scary visions of causing harm to baby • Excessive checking of baby Anxiety: • Worry about feeling or being crazy • Fear of telling others about their thoughts (a professional needs to label and help them identify their thoughts)	• Lack of interest in baby • Poor self care • Loss of interest in activities • Decreased energy and motivation • Withdrawal from friends and family (no energy; anxiety and fear of being watched or judged) • Inability to think clearly or make decisions Anxiety: • Excessive checking (hypervigilance) • Avoids social situations (thus risking isolation) • Tension with husband/others • Inability to let others help (as others are not good enough)	• Exhaustion • Sleep disturbance (*e.g.*, unable to sleep even when baby sleeps; mother tired despite having slept) • Headaches, chest pains, hyperventilation, heart palpitations

PPD: Post-partum depression

reproductive health specialists are aware of the unique post-partum risks and the distinct way that symptoms present during the post-partum period.

PPD risks apparent during pregnancy

Some PPD risk factors can be recognized before birth. As seen through the clinical counselling lens, the risk factors that follow are provided for guidance and not as a wholly comprehensive list.

Poor marital relationship

Studies have shown that a poor marital relationship is the most consistent psychosocial predictor of PPD.

Young or single women

A woman who is young or single, or both, is more at risk of PPD than the general population. These risks can be exacerbated when a woman is prone to isolation due to a lack of significant family support, or due to cultural or linguistic gaps.

History of mental illness

Pregnant women with a current diagnosis of a major depressive disorder or who have a history of PPD or puerperal psychosis are at the highest risk of PPD; it is essential that they be closely monitored and treated throughout the child-bearing period. Symptoms that a woman could control and manage before birth may intensify after birth. Women who are depressed in the third trimester are highly likely to continue their depression during the post-partum period.

Substance abuse

A presence or history of substance abuse is a risk factor for PPD. The co-existence of substance abuse and other mental health issues is common.

Past reproductive trauma

A woman may be more at risk of PPD having experienced trauma or significant difficulty in a previous pregnancy, birth or post-partum period.

PPD risks after birth

The following risk factors may not be recognized as PPD risks until after birth:

- Complicated birth
- Feeling incompetent as a mother
- Infant health issues
- Another major life change coincides with birth (*e.g.*, a move; change or loss of employment for the woman's partner; loss of a loved one; a major financial event)
- Lack of partner support. The role played by a husband or partner in a couple's relationship can lead to a supportive milieu for the infant's growth, or it can add stressors and instability.

In addition to the 50% to 80% of women who experience transient "baby blues," between 10% and 15% continue on to develop PPD.

PPD treatment options

Therapy, support networks and medicines (*i.e.*, antidepressants) are used to treat PPD. Psychotherapy has been shown to be an effective treatment and an acceptable choice for women who wish to avoid taking medications while breastfeeding.

When a woman has been identified as suffering from PPD, all treatment options should be reviewed with the patient and, when possible, her partner.

Based on depression studies, depression scores of women receiving counselling, cognitive-behavioural therapy, interpersonal psychotherapy, or partner support decrease significantly when compared to those of women not receiving such therapies.

When a practitioner is considering the inclusion of medication in the treatment plan, consultation is recommended with an expert in perinatal pharmacology before the start of treatment. When a woman is not accepting medication prescribed by a GP, possibly citing concern for the health of the breastfeeding baby, the woman should be referred immediately to a community practitioner who specializes in clinical or psychiatric issues.

Conclusion

PPD challenges the well being of women and their families at an important period during child development and family formation.

PPD afflicts women of all childbearing years and of all socio-economic groupings. Still, practitioners can experience much success in the identification of PPD symptoms by using available screening and diagnostic tools. This is particularly the case when they are attuned to:

- their patient's history with mental health issues and reproductive events,
- the level of support for a woman and baby by the woman's partner and close family and
- the level of stability in other areas of the woman's life.

Health professionals may find that success in the recognition of PPD relies more on the use of softer patient skills that can open the way for patient and practitioner to get to the heart of the matter.

Detection, diagnosis and treatment of women with PPD is critical at a vulnerable time for a women, their partner and their baby. Dx

For resources, please contact **diagnosis@sta.ca**