Postpartum and Perinatal Depression and Anxiety

By Dr. Laura Fadell

"I started to experience a sick sensation in my stomach; it was if a vise were tightening around my chest. Instead of the nervous anxiety that often accompanies panic, a feeling of devastation overcame me. I hardly moved. Sitting on my bed, I let out a deep, slow, guttural wail. I wasn't simply emotional or weepy, like I had been told I might be. This was something quite different. This was a sadness of a shockingly different magnitude. It felt as if it would never go away."

-from "Down Came the Rain: My Journey Through Postpartum Depression"
Brooke Shields, 2005

We have all heard of postpartum depression (PPD), especially with up to 80% of women experiencing some form of depressive symptoms following childbirth with some continuing through the first 12 months. Someone we know, or know of, has likely experienced some form of "baby blues", sadness, or even severe depression. Unfortunately, despite this high rate of occurrence, not all obstetricians or pediatricians routinely screen for PPD. In fact, more often than not, it is the woman herself who recognizes the symptoms and asks for help, and yet PPD is still underdiagnosed (Spinelli, 1998; Georgiopoulos, 2001). For example, in one study of outpatients from an obstetrics practice, only 6.3% were spontaneously identified as suffering from PPD; however, when they were screened using the Edinburgh Postnatal Depression Scale, the detection increased to 35.4% (Evins, Theofrastous, Galvin, 2000 – scale provided at the end of this article).

Risk factors for developing PPD include: (1) younger maternal age, (2) lower education, (3) personal or family history of mood disorder, (4) depression during pregnancy, (5) psychosocial stress, (6) lack of social support, (7) marital or relationship conflict, (8) financial pressures, (9) recent loss or disappointment, (10) low self-esteem, (11) complicated pregnancy or birth, (12) difficulty nursing, (13) difficult baby, and (14) being separated from newborn due to medical issues (e.g., infant in NICU).

Symptoms of PPD includes having the "baby blues" that do not fade after 1-2 weeks; strong feelings of depression and anger that start 1-2 months after childbirth; feelings of sadness, doubt, guilt, or helplessness that increase each week and get in the way of normal functioning; not being able to care for yourself or your baby; trouble doing tasks at home or on the job; changes in appetite; things that used to bring you pleasure no longer do; intense concern and worry about the baby or lack of interest in the baby; fears of harming the baby; and thoughts of self-harm (American College of Obstetricians and Gynecologists, 2006).

PPD puts mothers at risk of future depression and untreated maternal depression can result in poor outcomes for the health and welfare of both mothers and their children. There is substantial empirical evidence that maternal depression can have a negative

impact on the cognitive, social, and behavioral development of children, including infants as young as three months of age.

In addition to depression, research I have come across has shown that women who are pregnant, or who have recently given birth, are at an increased risk of developing anxiety, especially in the form of Obsessive-Compulsive Disorder (pOCD). The difference between "regular" OCD and pOCD is that the prior tends to begin gradually, while pOCD occurs more rapidly and coincides with feelings of being responsible for the newborn. In pOCD, the anxiety is usually focused on the newborn (or unborn) infant. Obsessions consist of the baby being hurt, contaminated, sick, or lost; and compulsions include checking, mental rituals, and seeking reassurance from others (Abramowitz, 2009). For example, I had one patient, a new mother, who would awaken and get out of bed multiple times a night to ensure her baby's blanket was covering the baby "just right" – translation: there were no wrinkles and the corners were squared up and even. I also worked with a young mother who became obsessed with checking her toddler for rashes and would spend literally hours each day examining every inch of skin for "dots." These are just a few examples of how I have seen pOCD manifest.

Treatment for PPD and pOCD can be very successful. The most promising method I have found is Cognitive-Behavioral Therapy (CBT) with an emphasis on Exposure and Response Prevention (ERP). This type of therapy emphasizes not only challenging irrational and unwanted thoughts, but also slowly exposes the person to the feared situation(s). During these "exposures", the person is not allowed to engage in any of the behavioral compulsions, which only serve to ameliorate their anxiety for brief periods. In addition, Selective Serotonin Reuptake Inhibitors (SSRIs) can also be quite beneficial for both depression and anxiety – depending upon the physician's recommendation for pregnant or nursing mothers.

Not all obstetric practices neglect screening for PPD and pOCD, but these are the exception rather than the rule, especially with regard to anxiety. I remain hopeful that screening will become universal, and have had the good fortune to work with some very fine physicians who do indeed make this standard practice in their offices.

Edinburgh Postnatal Depression Scale (EPDS)

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt IN THE PAST 7 DAYS, not just how you feel today.

In the past 7 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 less than I used to
   ___ 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
   ___ Not very often
   ___ No, not at all

*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

Source: Cox, JL; Holden, JM, and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150: 782-786.

Scoring:

Questions 1, 2, and 4 (without an *) are scored 0, 1, 2, or 3 with top spot scored as 0 and the bottom spot scored as 3.

Questions 3, 5, 6, 7, 8, 9, and 10 (marked with an *) are reverse scored, with the top spot scored as a 3 and the bottom spot scored as a 0.

Maximum Score:	30
Possible Depression:	10 or greater

Mothers who score above 13 are likely to be suffering from a depressive illness of varying severity. The EPDS score should not override clinical judgment. A careful clinical assessment should be carried out to confirm the diagnosis and determine what treatment is necessary.