

HEALTH & SCIENCE

Beyond the baby blues: A spectrum of postdelivery conditions


Asking the right questions is central to diagnosing and treating postpartum disorder.

By [Kathleen Phalen Tomaselli](#), *AMNews* correspondent. Feb. 18, 2008.

Katherine Stone, a successful marketing executive, felt as if she was in a bubble, watching a world she once knew pass in strange, sometimes frightening ways.

Within six weeks after her son's birth, her behavior became unfamiliar. She would drive through stop signs and think, "Oh my God, what am I doing?" She felt disconnected from friends and family -- as if her brain no longer worked. "I didn't even know who I was."

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And her thoughts -- "What if I take this burp cloth and smother him?" or "What if the knife slips and I stab him?" -- repulsed her. Still, she tried to rationalize the irrational, telling herself she was a well-educated woman who loved her baby, who could handle motherhood. "And to be sure I prevented any harm to my son, I made a pact with myself: If I make any real move toward hurting him, I will either run into the neighborhood screaming for help or I will get my husband's gun and shoot myself in the guest bedroom."

Stone experienced postpartum obsessive-compulsive disorder, a form of postpartum mood disorder. But a lack of knowledge and a profound fear that social services would remove her son pushed her further into this foreign world.

"In our society, the stigma about depression and an idealized picture of motherhood make asking for help very difficult," said Marlene P. Freeman, MD, director of the Women's Mental Health Center and associate professor of psychiatry, obstetrics and gynecology at the University of Texas Southwestern Medical Center. "Sometimes these mothers experience obsessions which are intrusive and disturbing thoughts about hurting the baby. These are different from psychotic thoughts a mother with postpartum psychosis might experience."

The eerie picture of Texas mother Andrea Yates in handcuffs after drowning her five children and the shocking news reports of Melanie Blocker-Stokes plunging 12 floors to her death from a Chicago hotel just months after her baby's birth come to mind. But these women experienced postpartum psychosis, a rare medical emergency associated with maternal suicide and infanticide that affects one to two women per thousand.

Some form of "baby blues" affects 8 of 10 women in the first two weeks after childbirth.

While postpartum depression and anxiety are common, affecting 10% to 20% of new mothers, postpartum mood disorders include postpartum panic disorder, postpartum obsessive-compulsive disorder, postpartum posttraumatic stress disorder and postpartum psychosis, many of which

are comorbid to postpartum depression. "About 50% have anxiety that is often more impairing than the depression," said Brian Stafford, MD, MPH, a pediatrician, pediatric and adolescent psychiatrist and medical director of the Kempe Center Postpartum Depression Intervention Program in Denver.

These conditions often are passed off as the very common baby blues, which affect eight out of 10 new mothers during the first two postpartum weeks. This circumstance contributes to PPD's standing as the most underrecognized, underdiagnosed and undertreated obstetrical complication in America, says the American College of Obstetrics and Gynecology.

Many reasons contribute to less-than-optimal diagnosis and treatment. "Stigma, lack of resources, lack of cohesion in medical and mental health systems, and a lack of funding in health care," Dr. Freeman said. "Obstetricians are on the front lines and often feel that they have not received enough training to treat psychiatric disorders, and psychiatrists often do not have enough training in treating pregnant and breastfeeding women."

Barriers to care

Women often feel pressured to play the role of the perfect mother with the beautiful baby, said Katherine L. Wisner, MD, professor of psychiatry, obstetrics, gynecology and epidemiology at the University of Pittsburgh School of Medicine. She also directs the Women's Behavioral Health Care Program at the Western Psychiatric Institute and Clinic. "They tell me, 'When I went to my obstetrician, I tried to look well,'" she said.

The illness also is hidden, noted Shoshanna Bennett, PhD, a San Francisco psychologist who experienced two life-threatening bouts of postpartum depression in the 1980s. "I plummeted into doom and gloom and felt my life was over." Dr. Bennett was then a special education teacher. "When I realized what I had was diagnosable and treatable and that my family didn't need to suffer, I started asking hospitals in the area if they would like me to teach their staffs about it."

Postpartum depression affects 10% to 20% of new mothers.

And so began a career dedicated to the study and support of women with postpartum mood disorders. Her efforts included educating local doctors. "Some physicians make the error of asking, 'Do you think you have postpartum depression?' That's like asking the patient to self-diagnose," she said. "Some women don't identify with depression. They might be short-tempered or worried all the time. That's why asking the right questions and screening is at the top of the list."

For Katherine Stone, though, like many in her situation, help did not come easily. Her psychiatrist knew little about the disorder and prescribed a cocktail of drugs -- one to make her happy, one to help her sleep, one to wake her -- which only exacerbated her problem. "What we need are psychiatrists familiar with both the pharmacology and behavioral health," said Nada Stotland, MD, a Chicago psychiatrist in private practice and the president-elect of the American Psychiatric Assn.

"This is a disease that lives between specialties," Dr. Wisner added. "Patients are running around in circles."

To further compound the difficulty, many communities lack mental health resources, insurance might not cover treatment and many physicians are not aware of local support systems. "Referral is quite a severe barrier to getting help," Dr. Stotland said. "No one wants to identify a serious condition they can do nothing about."

Fathers get depressed, too

Postpartum depression doesn't affect only mothers -- it takes its toll on entire families. According to a study in the August 2006 *Pediatrics*, researchers at the Center for Pediatric Research at the Eastern Virginia Medical School in Norfolk found that 10% of fathers showed signs of moderate or severe postpartum depression. "Men have the highest risk factor if their wife is depressed," Dr. Bennett said. "They often don't manifest the same way. Men might have a full-blown obsessive-compulsive reaction. They might be angry or impatient."

Then there is the effect of PPD on infants. A growing body of evidence points to delayed motor and cognitive skills. Infants of clinically depressed mothers may withdraw from daily activities and avoid any kind of interaction with caregivers. They may be more irritable and difficult to soothe. "Imagine the experience for the baby with no positive emotion," Dr. Stafford said. "When the infant first smiles, the mom doesn't smile back, and so they develop negative behaviors."

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More pediatricians are including postpartum screening of both parents during well-baby checkups. At Colorado's Kempe Center, new mothers and babies attend a 15-week series based on a model developed by Roseanne Clark, PhD, an assistant professor of psychiatry at the University of Washington who directs the Parent-Infant and Early Childhood Clinic and the Postpartum Depression Treatment Program.

"If a mother is treated with medication, that doesn't address the maternal-child bond," said Terri James-Banks, director of social work at the Kempe Center. At the program, mothers are in a peer support group while babies are with infant development specialists. Parent and baby are reunited at the end of each session.

Ninety-five percent of participants complete the entire series, James-Banks said. "When moms find out they are not alone, a big burden is lifted. Every mother we work with said, 'We received no information about postpartum depression, so we didn't know about it.' When mothers and fathers are able to put a name to it, they feel they can do something."

Primary care intervention

Because the condition is marked by many symptoms -- insomnia, appetite changes, persistent sadness, excessive worry, thoughts about harming the baby, irritability, anger, anxiety, self-doubt, difficulty concentrating, confusion, guilt and obsessive behaviors -- and because many women may not spontaneously disclose what's happening, screening tools like the Edinburgh Postpartum Depression Scale can help.

Several researchers, such as Lisa Baker, PhD, assistant professor of social work at the University of Alabama at Birmingham, have investigated the efficacy of such tools. In a study scheduled for publication this spring in the *Community Mental Health Journal*, Dr. Baker found that when a systematic screening using the Beck Scale -- more detailed than the Edinburgh -- was used, about 22% of 498 women were discovered.

Thus, another challenge is to screen routinely, said Erika Nichelson, MD, a Baltimore obstetrician and gynecologist who admits to postpartum depression herself. "I don't use the scale, but I ask all my patients. [Doctors] have to ask. We see [new mothers] at six weeks, and if they appear well and we don't ask, we won't see them again until their annual exam," she says.

Pursuing the right questions is key. Examples to use: "It's a big deal to have a new baby. How's it going for you?" "When you put the baby down for a nap, are you able to sleep?"

Nonetheless, Dr. Stotland recognizes it's not easy to add another type of screening to a jam-packed appointment. What happens if the patient starts crying and the physician has a waiting room full of

patients? An approach she recommends is to acknowledge the patient's situation and tell them, "I want to hear more about this." The physician can leave the room for a few minutes to allow the patient to collect herself. During that time, the doctor can see another patient and then return for a meaningful conversation.

Still, there are often too few resources, Dr. Freeman said. "Efforts to increase detection are going to be most effective in communities where health care provider education is also delivered," she said. "Perhaps the problem that we can change as soon as possible is making sure that health [professionals] and communities are better educated. The optimal situation would be that [they] would work as a team in screening, diagnosing, referring and treating women with postpartum depression."

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ADDITIONAL INFORMATION:

Mood swings

The following statements are excerpts from the Edinburgh Postnatal Depression Scale. Patients' responses indicate the frequency with which they experience these feelings. The full screening tool is available online in pdf format (www.aap.org/practicingsafety/toolkit_resources/module2/epds.pdf).

- I have been able to laugh and see the funny side of things.
- I have blamed myself unnecessarily when things went wrong.
- I have felt scared or panicky for no good reason.
- I have been so unhappy that I have difficulty sleeping or have been crying.
- The thought of harming myself has occurred to me.

Source: J. L. Cox, J.M Holden, R. Sagovsky, Dept. of Psychiatry, University of Edinburgh