

Differentiation and Clinical Implications of Postpartum Depression and Postpartum Psychosis

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ABSTRACT

Postpartum depression and postpartum psychosis are serious mood disorders encountered by nurses working in a variety of settings. Postpartum depression refers to a nonpsychotic depressive episode, while postpartum psychosis refers to a manic or affective psychotic episode linked temporally with childbirth. The nursing profession plays a crucial role in the early identification and treatment of these postpartum mood disorders. This article explains the classification, clinical presentation, epidemiology, management, and long-term outcomes of postpartum depression and postpartum psychosis.

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Mood disorders in the postpartum period are serious mental health conditions that negatively affect many women from diverse cultures. Postpartum mood disorders are commonly classified into three categories: postpartum blues, postpartum depression (PPD), and postpartum psychosis (PP). However, the terms PPD and PP are often used interchangeably. Confusion regarding the correct use of PPD and PP can have numerous clinical and research implications including inappropriate diagnoses and treatment regimes. If left untreated, both disorders can result in negative consequences including the risk of recurrent psychiatric illness (Cooper & Murray, 1995; Robertson, Jones, Haque, Holder, & Craddock, 2005), marital dysfunction (Meighan, Davis, Thomas, & Droppleman, 1999; Robertson & Lyons, 2003), suicide (Appleby, Mortensen, & Faragher, 1998), and infanticide (Spinelli, 2004). Research on PPD has shown that the infant is at risk for behavioral problems (Beck, 1999), delayed cognitive or psychosocial development (Beck, 1998; Grace, Evindar, & Stewart, 2003), and impaired mother-infant bonding (Beck, 1995). Most new mothers interact with nurses in the postpartum period. Accordingly, it is important that nurses have a good understanding of PPD and PP in order to provide the best possible care for women experiencing

these disorders. The purpose of this paper is to provide a clear understanding of the classification, clinical presentation, epidemiology, management, and long-term outcomes of PPD and PP.

Classification and Clinical Presentation

The classification of postpartum mood disorders has been a source of contention for many years. The argument concerns whether these disorders should be classified as distinct entities or be considered as part of existing conditions (Brockington, 1996). Most experts agree that PPD and PP are not distinct diagnostic entities. The current psychiatric classification systems, the Diagnostic and Statistical Manual of Mental Disorders, 4th ed., Text Revision (DSM-IV-TR) (American Psychiatric Association [APA], 2000), and the International Classification of Diseases, Tenth Revision (ICD-10) (World Health Organization, 1992) reflect this view and use a postpartum onset specifier within categories. The DSM-IV-TR defines postpartum onset to be within 4 weeks of delivery and can be used for various mood disorders, brief psychotic disorder, or psychotic disorder not otherwise specified. The ICD-10 defines postpartum onset to be within 6 weeks of delivery and can be used for mental

Nurses who interact with mothers in the postpartum period must have a good understanding of postpartum depression and postpartum psychosis.

disorders that do not meet the criteria for mental and behavioral disorders classified elsewhere.

Postpartum Depression

Research consistently demonstrates that PPD does not differ in symptomatology from major depression (Brockington, 1996); hence, in most cases, PPD is diagnosed as a major depressive episode with postpartum onset (Ross, Dennis, Robertson Blackmore, & Stewart, 2005). To classify as PPD, there must be a minimum period of 2 weeks in which the woman presents with depressed mood or loss of interest or pleasure in daily activities that represents a change from normal behavior and causes impairment in everyday functioning (APA, 2000). At least four of the following symptoms must also be present for a diagnosis: weight change in absence of dieting, insomnia or hypersomnia, psychomotor agitation or retardation, fatigue or loss of energy, feelings of worthlessness or guilt, decreased ability to think or concentrate, and recurrent thoughts of death or suicide (APA). The symptoms of PPD often have a greater emphasis on childrearing and may include intrusive thoughts about harming their infant or feelings of guilt about being a poor mother.

Mild hypomanic symptoms in the early postpartum period are also common among women who develop PPD (Heron, Craddock, & Jones, 2005). Glover, Liddle, Taylor, Adams, and Sandler (1994) examined the early symptoms of PPD among 198 women and found that 50% who were hypomanic in the first 3 days postpartum experienced PPD at 6 weeks, compared with only 18% of women who demonstrated no psychopathology. The postpartum blues are often confused with PPD, despite the difference in symptom severity, onset, and duration. Symptoms of PPD impair function, present throughout the first year postpartum, and persist for greater than 2 weeks in duration, while postpartum blues are often mild, transient, and present within the first few days after delivery (Brockington, 1996).

Postpartum Psychosis

The classification of PP is more complex, given the range of symptoms that can occur and the fact that the clinical picture can change rapidly. The differential diagnosis for PP episodes can include major depression with psychotic features, bipolar I, bipolar II, schizoaffective, unspecified functional

psychosis, and brief psychotic disorder. Studies show that most cases of PP represent a variant of bipolar disorder triggered by childbirth (Brockington et al., 1981; Jones & Craddock, 2001; Kendell, Chalmers, & Platz, 1987). A presentation of PP can be predominately depressive and differs from PPD in that delusions, hallucinations, confusion, perplexity, or manic or mixed features are present (Brockington, 1996). Episodes of postpartum schizophrenia are rare with a relative risk of less than one in the postpartum period; this compares with a 22-fold risk of affective psychosis (Terp, Engholm, Moller, & Mortensen, 1999). Schizophrenia episodes are not considered to be cases of PP.

The core feature of PP is mood disturbance, most commonly mania, although women often fluctuate rapidly between elation and depression and show significant mood lability. Symptom onset is often sudden and unexpected, usually occurring within 48 hours to 2 weeks after giving birth (Brockington, 1996). While experts have reported that there is a symptom-free period during the first 48 hours postpartum (Brockington; Hamilton, 1962), more recent research suggests that approximately one half of women present with mild hypomanic symptoms within the first 3 days postpartum (Heron, McGuinness, Robertson, Craddock, & Jones, 2008). The clinical presentation of PP progresses rapidly following these early mood symptoms, and is characterized by delusions, hallucinations, bizarre behavior, and mood lability (Heron et al.). The nature of the psychotic symptoms varies widely and often the delusions include religious themes. Visual, auditory, and olfactory hallucinations have been reported and can include commands to hurt oneself or the baby. Although it is generally agreed that the clinical presentation of PP is similar to mania or affective psychosis independent of the postpartum period, some researchers suggest that PP presents with more severe confusion and perplexity (Brockington et al., 1981; Kirpinar, Coskun, Çayköylü, Anaç, & Özer, 1999; Kisa, Aydemir, Kurt, Gulen, & Goka, 2007).

Epidemiology

Epidemiologic studies demonstrate that women are more likely to be admitted to a psychiatric unit after giving birth than at any other time in their lives (Kendell et al., 1987; Munk-Olsen, Laursen, Pedersen, Mors, & Mortensen, 2006). There has long been debate as to whether the postpartum period is a time of increased risk for mood disorders. Although the overall prevalence of depression does not appear to be higher in women after delivery as compared

with age-matched comparison women (Cox, Murray, & Chapman, 1993), serious depression requiring admission to hospital is clearly more prevalent (Kendell et al.). Episodes of PPD and PP can occur with women who experience symptoms solely after childbirth; may represent the first episode of a psychiatric disorder; or may be an exacerbation of a pre-existing psychiatric disorder (Baker, Mancuso, Montenegro, & Lyons, 2002).

Postpartum Depression

The prevalence of PPD ranges across studies from 4.5% to 28% (Scottish Intercollegiate Guidelines Network, 2002). A frequently cited meta-analysis of 59 studies demonstrated that 13% of mothers experience PPD within 12 weeks following delivery (O'Hara & Swain, 1996), while a more recent report suggests rates as high as 15% in community samples (Gaynes et al., 2005). The variability in rates can be attributed to sampling, timing of assessment, different diagnostic criteria, and whether the study is retrospective (lower rates) or prospective (higher rates) (Dennis & Hodnett, 2007). While PPD can occur within the first year postpartum (Goodman, 2004), rates often peak at 12 weeks (Gaynes et al.).

Meta-analyses including prospective studies have consistently demonstrated that women who have a history of depression and experience depression or anxiety during pregnancy are at increased risk for developing PPD (Beck, 2001; O'Hara & Swain, 1996; Robertson, Grace, Wallington, & Stewart, 2004). Research also shows that a family history of psychiatric illness increases the risk of PPD (Steiner, 2002). The rapid decline in reproductive hormones (e.g., estrogen and progesterone) and altered cytokines profiles that follow after delivery are suggested to play a role in the development of depressive symptoms in women who are susceptible (Bloch et al., 2000; Groer & Davis, 2006; Wisner, Parry, & Piontek, 2002). While biological factors potentially contribute to vulnerability of developing PPD, there is no clear evidence to identify one causal biochemical or hormonal factor (Gentile, 2005; Seyfried & Marcus, 2003). Moreover, it has been suggested that biological factors play an indirect role in the development of depressive symptoms as a mediator through psychosocial factors (Ross, Sellers, Gilbert Evans, & Romach, 2004).

Several psychosocial variables have been reported as contributing factors in the development of PPD. In particular, stressful life events and low levels of perceived social support are consistently associated with increased risk (Dennis & Letourneau, 2007;

Logsdon, Hertweck, Ziegler, & Pinto-Foltz, 2008; Logsdon & Usui, 2001). A woman's relationship with her partner is also a predictive variable (O'Hara & Swain, 1996), with women who report lower levels of satisfaction, quality, social integration, appraisal support, problem-focused informational support, and higher levels of conflict potentially at greater risk for developing PPD (Dennis & Ross, 2006). Additional risk factors include low self-esteem, childcare stress, severe maternity blues, infant temperament (Beck, 2001), and maternal fatigue (Dennis & Ross, 2005).

Postpartum Psychosis

The incidence of PP resulting in hospital admission is approximately 1 to 2 in 1,000 deliveries (Kendell et al., 1987; Munk-Olsen et al., 2006). Women who have a history of bipolar disorder are particularly vulnerable to experiencing PP, with rates between 25% and 50% (Brockington, 1996; Jones & Craddock, 2001). A personal history of PP predisposes approximately 57% of women to experience another episode after a subsequent pregnancy (Garfield, Kent, Paykel, Creighton, & Jacobson, 2004; Pfuhlmann, Franzek, Beckmann, & Stöber, 1999; Robertson et al., 2005).

There is increasing evidence to support the role of genetics in PP (Coyle, Jones, Robertson, Lendon, & Craddock, 2000; Jones & Craddock, 2007). Particularly interesting is the extremely high risk of PP (74%) in parous bipolar women who also have a first-degree relative with a history of PP (Jones & Craddock, 2001). No specific gene has yet been shown as placing women at greater risk for PP, although advances in research are promising in this direction (Jones & Craddock). Rapid hormonal changes after pregnancy are suggested to play a role in the development of PP. There is evidence that changes in the levels of estrogen, prolactin, progesterone, adrenocorticoids, and thyroid hormones precede the onset of PP, although the evidence remains equivocal (Brockington, 1996; Seyfried & Marcus, 2003).

Primipara women are consistently reported to be at greater risk of experiencing PP (Agrawal, Bhatia, & Malik, 1997; Kendell et al., 1987; Kisa et al., 2007; Robertson Blackmore et al., 2006; Videbech & Gouliaev, 1995). Kendell and colleagues demonstrated that this finding was not explained by age or the avoidance of future pregnancies among women who experience an episode of PP after their first pregnancy. In a more recent study, however, first-time mothers who were older had a greater risk

of developing PP, with women between the ages of 40 and 44 at greatest risk (Nager, Johansson, & Sundquist, 2005). This finding has important implications, given that many women are waiting longer to start having children. Women who experience sleep loss also appear to be particularly vulnerable to the development of PP (Sharma & Mazmanian, 2003).

Other risk factors for PP include living in a poor socioeconomic neighborhood (Nager, Johansson, & Sundquist, 2006), having a female child (Agrawal et al., 1997; Kendell et al., 1987), delivery by Cesarean section (Kendell et al.), complications during delivery (Robertson Blackmore et al., 2006), preterm delivery, low birth weight (Videbech & Gouliaev, 1995), and perinatal death (Kendell et al.). Evidence to support these risk factors is inconclusive, as other researchers have reported insignificant findings for the same risk factors (Kendell et al.; Robertson Blackmore et al.; Videbech & Gouliaev). Research on marital status remains equivocal, with some studies demonstrating that married women are at greatest risk (Kirpinar et al., 1999; Protheroe, 1969), while other research suggests that unmarried women are at higher risk (Kendell et al.; Nager et al., 2005). The close timing of PP to childbirth, sudden onset, relative dissociation from social consequences, high relapse rate (Murray, Cooper, & Hipwell, 2003), and consistent prevalence cross-culturally (Kumar, 1994) all point to a biological etiology of PP.

Prevention and Treatment

Both PPD and PP are highly treatable disorders, and given that they are not considered to be qualitatively different than depression and mania or affective psychosis outside the postpartum period, there is no evidence to suggest that interventions outside the postpartum period would not be as effective postnatally. Prevention and treatment interventions for women experiencing postpartum mood disorders are guided by severity of symptoms, underlying mental illness, past response to treatment, women's preferences, and breastfeeding status (Nonacs & Cohen, 1998; Sit, Rothschild, & Wisner, 2006).

Postpartum Depression

Prevention

Based on a Cochrane meta-analysis conducted by Dennis and Creedy (2004), there are no prenatal psychosocial or psychological interventions that can be empirically recommended for the prevention of PPD. There is preliminary support, however, for the effects of weekly postpartum nursing home

visits (Armstrong, Fraser, Dadds, & Morris, 1999) and midwifery home visits that are flexible, individualized, and utilize PPD screening tools (MacArthur et al., 2002). Telephone-based peer support also has the potential to decrease the risk of depressive symptomatology among mothers (Dennis, 2003). Dennis and Creedy reported that preventive interventions targeting women considered to be at risk were more effective in preventing PPD than interventions targeting the general maternal population. The efficacy of antidepressants in preventing PPD remains equivocal (Howard, Hoffbrand, Henshaw, Boath, & Bradley, 2005).

Treatment

Psychosocial and psychological interventions are frequently used in the treatment of PPD. Many women prefer nonpharmacological interventions, due to the potential transmission of medication into breast milk, fear of addiction or dependence, or adverse side effects (Dennis & Chung-Lee, 2006). A recent Cochrane review evaluated the effect of psychosocial and psychological interventions on the treatment of PPD and found that nondirective counseling, cognitive behavioral therapy, interpersonal psychotherapy (IPT), psychodynamic therapy, and telephone-based peer support may all be effective treatment options (Dennis & Hodnett, 2007). Interpersonal psychotherapy is also effective as a long-term support measure to prevent future episodes of depression (Stuart & O'Hara, 1995). In an earlier comprehensive review conducted by Dennis (2004), the potential beneficial treatment effects of peer and partner support, massage therapy, infant sleep interventions, mother-infant relationship therapy, and maternal exercise were also reported. As many of the trials evaluating PPD treatment interventions in this review had significant methodological limitations, the results should be interpreted with caution. While psychosocial and psychological treatment options are important, many women also require pharmacotherapy. The effects of antidepressants are the same as for general depression; however, for PPD there is the additional consideration of whether the mother is breastfeeding (Seyfried & Marcus, 2003). The treatment effects of hormones (e.g., estrogen and progesterone) remain equivocal (Ahokas, Kaukoranta, Wahlbeck, & Aito, 2001; Gregoire, Kumar, Everitt, Henderson, & Studd, 1996; Lawrie et al., 1998).

Postpartum Psychosis

Prevention

Research on the prevention of PP is primarily limited to pharmacotherapy. Given the association of PP

with bipolar disorder, mood stabilizers such as lithium are commonly used as a prophylactic measure and dramatically reduce the risk of a relapse postnatally (Cohen, Sichel, Robertson, Heckscher, & Rosenbaum, 1995; Stewart, Klompenhouwer, Kendall, & van Hulst, 1991). Further support for the use of lithium is based on studies demonstrating high relapse rates among women who discontinue current use (Viguera et al., 2000). The prophylactic effect of olanzapine was demonstrated in one open clinical trial (Sharma, Smith, & Mazmanian, 2006), while the prophylactic use of hormone therapy (e.g., estrogen) remains equivocal (Kumar et al., 2003; Sichel, Cohen, Robertson, Ruttenberg, & Rosenbaum, 1995).

Treatment

There is a dearth of treatment trials on PP and the majority of research to date consists of case reports. Because of the severity of PP, hospitalization is often required and interventions are predominantly biological in nature. Pharmacotherapy is the first line of treatment and preliminary evidence supports treatment with mood stabilizers and hormones (Sharma, 2008). Electroconvulsive therapy is also effective in treating severe and treatment-resistant cases of PP (Forray & Ostroff, 2007). The effects of antidepressants in the treatment of PP with primarily depressive features are not well researched and caution is warranted due to the risk of antidepressants causing rapid cycling in bipolar patients (Sharma, 2002).

Long-Term Outcomes for Affected Women

Postpartum Depression

Numerous studies have examined the long-term outcomes of PPD. Most women who receive treatment recover within 12 weeks (Cooper & Murray, 1995), while up to 15% of women will continue to experience depressive symptoms for greater than 24 weeks (Cooper, Campbell, Day, Kennerley, & Bond, 1988). The course of PPD is often prolonged because of a delay in diagnosis or inadequate treatment (Scottish Intercollegiate Guidelines Network, 2002). Stigma and shame frequently prevent women from obtaining the required treatment (Beck, 2002; Dennis & Chung-Lee, 2006; Letourneau et al., 2007). Women who experience PPD are prone to relapses, with at least 25% of women experiencing future nonpostpartum episodes (Wisner et al., 2002) and 41% relapsing after a subsequent pregnancy (Wisner, Perel, Peindl, & Hanusa, 2004). Cooper and Murray found that women who had no prior history of depression were

at greater risk for relapses postnatally, but not at increased risk for nonpostpartum episodes. In contrast, they found that women who had previous episodes of depression had increased risk for nonpostpartum relapse, but not for postpartum episodes.

Postpartum Psychosis

Outcome studies of PP show stability between the initial clinical presentation of postpartum episodes and lifetime diagnosis (Protheroe, 1969; Robling, Paykel, Dunn, Abbott, & Katona, 2000). For example, a woman who initially presents with postpartum mania and experiences a subsequent psychiatric episode usually continues to experience a bipolar illness. The majority of women who experience PP have favorable outcomes with full recovery. The prognosis of PP is better than for women who experience mania or psychosis outside the postpartum period (Kirpinar et al., 1999); however, relapses are common. It is estimated that 62% of women who experience PP suffer a subsequent affective episode outside the postpartum period, while approximately 57% experience a relapse after a subsequent pregnancy (Robertson et al., 2005). There is also a high risk of suicide, affecting approximately 4% of women who experience PP (Pfuhmann, Stoeber, & Beckmann, 2002).

Psychosis solely in the postpartum period is associated with the best outcomes in terms of illness, employment, and social functioning (Dean, Williams, & Brockington, 1989), although only 20% experience no further psychopathology (Pfuhmann et al., 1999; Schopf & Rust, 1994). A family history of mental illness predicts a shorter time to recurrence outside the postpartum period (Robertson et al., 2005).

Comparing PPD and PP

Table 1 outlines the principle differences between PPD and PP with respect to the prevalence, risk factors, onset, symptoms, management, and long-term outcomes of these disorders. A noticeable difference is the prevalence and onset times. The risk factors for both PPD and PP are complex and multifactorial. While PPD is often predicted by psychosocial factors, PP is generally predicted by biological factors. The approach to treatment also differs. Postpartum depression is most commonly managed by a primary health professional (e.g., family physician and public health nurse) and occasionally by a psychiatrist if resources exist, while PP is routinely managed in the hospital. The treatment of PPD often includes psychosocial and

Table 1: Comparing Postpartum Depression (PPD) and Postpartum Psychosis (PP)

	PPD	PP
Prevalence	13%-15%	0.1%-0.2%
Risk factors	Personal history of depression Depression/anxiety during pregnancy Family psychiatric history Hormonal changes Life stress Low social support Poor marital relationship	Personal/family history of PP Personal/family history bipolar disorder Genetics Hormonal changes Primiparity Sleep loss
Onset	2 weeks to 1 year postpartum	Sudden, usually within 2 weeks postpartum
Symptoms	Nonpsychotic depression <ul style="list-style-type: none"> • Depressed mood • Loss of interest • Weight change • Insomnia or hypersomnia • Psychomotor agitation • Fatigue or loss of energy • Feeling worthless or guilt • Decreased concentration • Thoughts of death or suicide 	Manic or affective psychosis <ul style="list-style-type: none"> • Mania • Mood lability • Delusions • Hallucinations • Bizarre behavior • Severe depression • Confusion • Perplexity

psychological interventions, while biological strategies are the main treatment for PP.

Nursing Implications

Childbearing women encounter nurses working in a variety of settings. Accordingly, nurses are ideally placed to screen, assess, and treat women experiencing postpartum mood disorders.

Table 1. Continued

	PPD	PP
Management	Nondirective counseling	Hospitalization
	Cognitive behavioral therapy	Mood stabilizers
	Interpersonal psychotherapy	Antipsychotics
	Psychodynamic therapy	Hormones
	Telephone-based peer support	ECT
	Antidepressants	Antidepressants (with caution)
	Hormones	
Long-term outcomes	25% have nonpostpartum episodes	62% have nonpostpartum episodes
	41% have postpartum episodes	57% have postpartum episodes
		Diagnostic outcomes are stable

Note. ECT = electroconvulsive therapy.

Screening

Improved recognition of at-risk women and early detection of postpartum mood disorders is essential, considering the high prevalence and potential adverse consequences. Nurses can play an integral role in educating women and their families prenatally about potential risk factors, early signs, and appropriate prophylactic measures. Women who experience anxiety or depressive symptoms in the prenatal period should be followed closely, as these symptoms are consistently predictive of PPD. Detailed personal and family psychiatric histories should be obtained from all women. The woman's family members are key informants; therefore, nurses should ask family members about changes in the woman's mood or behavior. Health professionals should also be aware that women who present without risk factors may still develop PPD or PP.

Postpartum depression is often more difficult to detect than PP, as many symptoms of depression are similar to somatic symptoms that normally occur

after childbirth. For example, weight and sleep disturbances are normal for women postpartum, but are also symptoms of depression. To elucidate whether changes in weight are a symptom of depression, nurses can ask women about their desire for food and if they continue to enjoy their favorite foods (Ross et al., 2005). Sleep disturbances can be assessed by asking women if they are able to rest or sleep when given the opportunity (Ross et al.). Fatigue is also difficult to assess. Fatigue associated with depression is a continual state of exhaustion, despite the amount of sleep or rest obtained (Ross et al.).

The Edinburgh Postnatal Depression Scale (EPDS) is a 10-item instrument used internationally to assess for PPD, and excludes questions about somatic discomforts (Cox, Holden, & Sagovsky, 1987). This standardized instrument is a self-report measure that assesses how postpartum women felt during the past 7 days. The EPDS takes only 5 minutes to administer, is free of charge (Horowitz & Goodman, 2005), and is readable at the third-grade level (Logsdon & Hutti, 2006). It has been validated in several different languages and cultures (DeRosa & Logsdon, 2006). It should be noted that the EPDS is not a diagnostic instrument or a replacement for diagnostic assessment, rather the EPDS is used to provide information on the severity of PPD symptoms (McQueen, Montgomery, Lappan-Graccon, Evans, & Hunter, 2008). While the best time to administer the EPDS is unknown (McQueen et al.), it has been recommended that the EPDS be administered anytime throughout the postpartum year to confirm depressive symptoms (Registered Nurses Association of Ontario, 2005). Women who report a score of 1 or greater on thoughts of self-harm (item 10) require immediate attention (Registered Nurses Association of Ontario), and appropriate treatment and referral mechanisms must be in place.

The Postpartum Depression Screening Scale (PDSS) (Beck & Gable, 2002) is a 35-item self-report scale, consisting of statements about how the mother may be feeling after the birth of her baby. The PDSS needs to be purchased, is written at a third-grade reading level and takes 5 to 10 minutes to complete. Statements relate to the previous 2 weeks and responses are given on a 5-point Likert scale ranging from "strongly disagree" to "strongly agree." Higher scores indicate higher levels of postpartum depressive symptoms. The scale comprises seven symptom content areas including: sleeping/eating disturbances, anxiety/insecurity, emotional lability, mental confusion, loss of self, guilt/shame, and suicidal thoughts. The PDSS yields a separate

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score for each of the seven scales, and the corresponding manual provides guidelines for interpreting scores on each of the scales. The scale can be used as a screening instrument for PPD from 2 weeks after delivery, and Beck and Gable recommended readministering the PDSS every 3 months during the first 12 months postpartum.

When screening for PP, nurses should look for signs of mood lability, euphoria, confusion, disorganization, delusional beliefs, hallucinations, and suicidal or homicidal ideations. Continual assessment of woman's sleep pattern is also important, as insomnia may represent an early symptom of PP (Sharma & Mazmanian, 2003). Assessing for early hypomanic signs within the first 3 days postpartum is also important, as these symptoms are predictive of both PPD and PP. These early signs can be difficult to detect, as many women perceive that they are simply coping extraordinarily well (Heron et al., 2008). The Mood Disorder Questionnaire (MDQ) is one instrument that can be used to assess for symptoms of hypomania and mania (Hirschfeld et al., 2000). The MDQ is a free self-report questionnaire that screens for bipolar disorder with 13 yes/no items derived from both DSM-IV criteria and clinical experience (Hirschfeld et al.). All questions begin with the statement "Has there ever been a period of time when you were not your usual self and . . ." Item examples include "you felt much more energy than usual" and "thoughts raced through your head or you couldn't slow your mind down." The MDQ has been translated into several different languages and is validated for use in psychiatric and general populations (Chung, Tso, Cheung, & Wong, 2008). While the MDQ is a screening instrument, it has a sensitivity of .73 and specificity of .90 against the DSM-IV diagnosis of bipolar disorder in a psychiatric outpatient population (Hirschfeld et al.). Research has demonstrated that the MDQ may be less effective with patients who have impaired insight or milder bipolar spectrum conditions (Miller, Klugman, Berv, Rosenquist, & Ghaemi, 2004).

Assessment

Once symptoms of PPD or PP are recognized, a complete medical history should be obtained and a full diagnostic workup completed to rule out other potential causes, such as thyroid dysfunction, diabetes, anemia, or autoimmune diseases (Ross

et al., 2005). Assessment of the woman's safety and the safety of her child(ren) is of highest priority, as women may experience suicidal or homicidal ideations. Inquiring about thoughts of suicide is required and any thoughts of self-harm should be taken seriously. Women should also be continually assessed for their thoughts and feelings toward their infant, as hallucinations and delusions, compounded with feelings of irritability and difficulty in controlling emotions, can lead to thoughts of infant harm. The partners of women diagnosed with postpartum mood disorders could also be assessed for symptoms of depression, given that maternal depression is a significant risk factor for paternal depression postnatally (Ballard, Davis, Cullen, Mohan, & Dean, 1994; Madsen & Juhl, 2007).

Treatment and Prevention

Timely treatment is important in order to prevent an increase in symptom severity. Unfortunately, many women who experience symptoms of PPD or PP are reluctant to seek help (Dennis & Chung-Lee, 2006; Kersting, Fisch, & Arolt, 2003) due to shame, fear (real or imagined) that their children will be taken away, a lack of insight into the seriousness of their illness, or simply because appropriate forms of health care services are either not available or not easily accessible (Dennis & Chung-Lee; Letourneau et al., 2007). Prenatally and before hospital discharge, postpartum women could be informed of the available services to access if symptoms develop and could be educated about the serious consequences of untreated illness.

Central to the treatment plan is educating the affected women and their families. Given the misconceptions portrayed in the media of women who experience mental health issues postnatally, women and their families should be educated about the potential causes, symptoms, and expected course of the illness. Any misconceptions or fears could be addressed at this time. Women should also be aware of the high rates of recurrence after subsequent pregnancies and outside the postpartum period, as many women are not informed of these risks (Robertson et al., 2005). Guidance can be offered on how to prevent or recognize early symptoms of mood disorders. It is important for women to be aware that avoiding further pregnancies will not guarantee preventing further illness (Robertson et al.).

Educating on the treatment regime is essential to ensure compliance. An open discussion on any fears or concerns with using pharmacotherapy

can occur, given the high refusal rates for this treatment option among depressed, manic, and psychotic women. Women and their families should be informed of the benefits and risks of treatment when breastfeeding. In particular, a discussion weighing the risks of untreated symptoms, particularly with respect to maternal-infant relationships and child development (Beck, 1995, 1999), with the risks of medication being transferred into breast milk must be clearly explained so that informed decisions about treatment and breastfeeding can be made (Viguera et al., 2000). Health professionals play a critical role in monitoring for adverse effects resulting from treatment (Wisner et al., 2002). Monitoring for adverse effects in infants who are breastfeeding is also important.

Psychosocial and psychological treatment interventions are also important. It is widely known that the women who experience postpartum psychiatric disorders who have more support have better outcomes. For example, women diagnosed with PPD who receive support from their partners have decreased depressive symptoms (Misri, Kostaras, Fox, & Kostaras, 2000) and shorter hospital stays (Grube, 2005). Unfortunately, women who experience postpartum mood disorders may have strained relationships with their partner, family, and friends. During discharge planning, it is important to ensure that women and their families have adequate support and resources in the community, as well as appropriate follow-up care. As such, nurses require a good understanding of what services are available in the community for women experiencing postpartum mood disorders. Family members can be taught therapeutic communication techniques, such as active listening and empathy, so they can appropriately provide support during the recovery period (Ugarriza, 1992). Nurses who have advanced training in psychiatric mental health nursing (e.g., nurse practitioners and clinical nurse specialists) are especially qualified to provide mental health treatment, such as IPT (Horowitz & Goodman, 2005).

Postpartum depression and PP are complex mood disorders that require interdisciplinary and biopsychosocial approaches to care that address the needs of affected women and their families. Nurses and other health professionals need to keep up-to-date with current research, in order to provide the most appropriate and beneficial care throughout the perinatal period. Improved training in undergraduate programs would provide the foundation necessary to care for this vulnerable population. Nurses can advocate that postpartum mood disor-

ders receive a greater place in nursing curriculums, as well as for ongoing educational programs for all health professionals.

Conclusion

Postpartum depression and PP are severe and debilitating disorders that affect women at a crucial time. Given that women are often in contact with health care services throughout the perinatal period, this represents an excellent window of opportunity for nurses to screen for PPD and PP and to assist in implementing preventative and treatment measures. Early identification and appropriate and timely treatment are critical to the well-being of the affected woman and her family. Collaboration among all health professionals is essential in order to detect and most effectively manage women experiencing postpartum mood disorders. Prenatally, and before hospital discharge postpartum, women should be educated about available services if symptoms develop and of the serious consequences of untreated illness. Given the serious consequences experienced by women who have postpartum mood disorders, coupled with the integral role of nurses in their care, an increased focus on postpartum mood disorders in nursing curriculums and training workshops deserves attention.

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