
Treating postpartum mood and anxiety disorders in primary care pediatrics



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Postpartum psychiatric disorders represent a significant public health problem that has not been readily addressed, particularly in the primary care setting. As maternal mood and anxiety difficulties are associated with a number of adverse outcomes for the mother, her offspring and the family system, addressing these concerns during the perinatal period is of critical importance. Although researchers and clinicians have become increasingly aware of the problem, postpartum mood and anxiety disorders (PMADs) remain widely unrecognized and poorly understood by both patients and providers. As pediatric primary care providers encounter mothers repeatedly throughout the postpartum period, the pediatric clinician has the unique opportunity to intervene with mothers suffering from mental illness. Given the potentially devastating impact of PMADs across multiple domains, the purpose

of this article is to provide guidelines for pediatric clinicians to better manage maternal mental illness within the primary care pediatric setting. As such, we review the categories and prevalence of PMADs and provide strategies for responding to a positive PMADs screen or concerns raised during surveillance of the mother–infant dyad. In addition, we offer a summary of the literature on evidence-based treatments for PMADs to allow pediatricians to guide the parents of their patients towards the most effective interventions. Finally, we provide an overview of alternative treatment models that can facilitate the screening and treatment of behavioral health concerns within the primary care setting.

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Each year between 8% and 25% of new mothers will be affected by postpartum depression (PPD).¹ Postpartum depression is not only a threat to a woman's well-being, but poses risk to mother–infant relationships and is a precursor to child developmental delays and subsequent child psychopathology.^{2–4} Postpartum depression can have long lasting effects for children, as children with depressed mothers are at an increased risk for child abuse and are more likely to exhibit insecure

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attachment patterns.⁵ When these children reach school age, they have higher rates of behavioral disturbance, particularly when children are exposed to violence in conjunction with parental depression.⁶

In addition to greater likelihood of poor developmental and social-emotional outcomes, depressed mothers may also be less likely to seek treatment for their children and utilize pediatric health

care services, further worsening health outcomes for at-risk children. As adults, the offspring of depressed mothers have higher rates of depression as well as other psychiatric disorders.⁷ In addition to the impact on women's long term well-being and children's development, untreated postpartum psychiatric disorders have a social economic toll. According to Wilder Research, the annual cost of not treating a mother with depression is \$7200 in lost income and productivity alone.⁸ When extrapolated to 800,000 mothers each year, the total annual cost of untreated maternal depression in the US is \$5.7 billion dollars.⁸

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Categories and Prevalence of Postpartum Mood and Anxiety Disorders

Postpartum is the term used to refer to the time following childbirth, while perinatal refers to the time before, during, and after a woman gives birth. According to the American Psychiatric Association *Diagnostic and Statistical Manual of Mental Health Disorders-V* (DSM-V), the term “peripartum” is used to describe onset of symptoms during pregnancy or in the first month following delivery. Importantly, although the DSM-V does not apply the same terminology to specifically address peripartum or postpartum anxiety disorders, such as panic disorder, obsessive–compulsive disorder, and phobia, these psychiatric conditions can also have an initial onset or exacerbation in the postpartum period. Categories of specific disorders will be described below.

Postpartum Depression

Major depression in the postpartum period is a significant public health problem affecting 8–25% of postpartum mothers.¹ Symptoms of PPD include sadness, anxiety, lack of energy, forgetfulness, frequent crying, sleeping problems, low self-esteem, hopelessness, feeling overwhelmed, appetite problems, and irritability or anger.⁹ Onset of mood symptoms can occur during pregnancy as well as postpartum, with 50% of major depressive episodes identified during the postpartum period beginning prior to the birth of the child. These “peripartum” depressive episodes are often associated with anxiety and panic attacks.¹⁰

Postpartum Bipolar Disorder

Bipolar disorder is characterized by severe mood swings. In a manic episode women affected by bipolar disorder may experience a decreased need for sleep, increased sex drive, inappropriate extreme happiness, speeding thoughts, impulsiveness, and an inflated ego.⁹ Similar to a diagnosis of depressive disorder, the peripartum onset can be specified if symptoms, including mania, hypomania or major depression, begin during pregnancy or in the first month following the birth of the child. Studies have shown that for women with bipolar disorder, 30–50% will experience

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symptoms during pregnancy, and 52% of women with bipolar disorder are likely to experience an episode postpartum, suggesting that the postpartum period is a time of heightened risk for women with a history of bipolar disorder.^{11,12}

Postpartum Anxiety Disorders

Anxiety disorders are diagnosed in approximately 16% of women, and include generalized anxiety disorder, obsessive–compulsive disorder, agoraphobia, specific phobia, social phobia, and posttraumatic stress disorder.¹³ Prevalence rates can increase to 50% when accounting for comorbid disorders, including major depression.¹⁴ While there is some evidence that the prevalence of some anxiety symptoms decrease over the course of pregnancy and postpartum, a recent meta-analysis suggested that women are at greater risk for obsessive compulsive disorder (OCD) during pregnancy and the postpartum period.^{15,16} Left untreated, postpartum anxiety disorders have been associated with negative outcomes for the mothers and developmental implications for infants.¹⁷

Postpartum Post Traumatic Stress Disorder (PTSD)

Researchers have begun to identify PTSD in women resulting from traumatic experiences during pregnancy or childbirth, or by a history of trauma before conception. While estimates of prevalence are typically 1–2%, it is likely that many more women suffer from symptoms, though do not meet criteria for diagnosis.^{15,18} Schwab et al.¹⁹ conducted the first prospective longitudinal study that demonstrated the high prevalence rate of PTSD among multiparous women. According to their findings 21% of women met criteria for a diagnosis of PTSD at 6 weeks postpartum. When controlling for previous traumatization, the rate of PTSD as a result of the most recent experience with childbirth remained just below 8%. Traumatic childbirth can reduce the strength of the mother–child bond as well as reduce the woman’s general adaptability and connections with others.¹⁹ Mother–infant attachment, parenting problems, fear of childbirth, and sexual avoidance have been identified as possible impacts of PTSD in postpartum mothers.²⁰

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