AWHONN Compendium of Postpartum Care

THIRD EDITION

Chapter 5: Postpartum Mood and Anxiety Disorders is provided here and excerpted from the AWHONN Compendium of Postpartum Care.

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PROMOTING THE HEALTH OF WOMEN AND NEWBORNS

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Third Edition

Editors:

Patricia D. Suplee, PhD, RNC-OB

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This Compendium was developed by AWHONN as an informational resource for nursing practice. The Compendium does not define a standard of care, nor is it intended to dictate an exclusive course of management. It presents general methods and techniques of practice that AWHONN believes to be currently and widely viewed as acceptable, based on current research and recognized authorities. Proper care of individual patients may depend on many individual factors to be considered in clinical practice, as well as professional judgment in the techniques described herein. Variations and innovations that are consistent with law and that demonstrably improve the quality of patient care should be encouraged. AWHONN believes the drug classifications and product selection set forth in this text are in accordance with current recommendations and practice at the time of publication. However, in view of ongoing research, changes in government regulations, and the constant flow of information relating to drug therapy and drug reactions, the reader is urged to check information available in other published sources for each drug for potential changes in indications, dosages, warnings, and precautions. This is particularly important when a recommended agent is a new product or drug or an infrequently employed drug. In addition, appropriate medication use may depend on unique factors such as individuals' health status, other medication use, and other factors that the professional must consider in clinical practice.

The information presented here is not designed to define standards of practice for employment, licensure, discipline, legal, or other purposes.

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The *AWHONN Compendium of Postpartum Care* (3rd Edition) (*Compendium*), is a comprehensive reference book targeted primarily to meet the needs of postpartum and mother-baby care nurses. This third edition was developed and updated by a team of AWHONN member experts who are nationally and internationally recognized for their significant contributions in maternal, low-risk, high-risk, and neonatal intensive care nursing. The editors, contributors and reviewers were selected for their expertise as clinicians, academicians, and researchers whose work is focused on improving the health and well-being of women, newborns, and their families. AWHONN gratefully acknowledges their dedication and diligence to ensure that the *Compendium* remains an essential evidence-based nursing resource.

Ensuring uniformity in content and professional guidance across all of AWHONN's education and practice resources is a fundamental principle of our work. As such, AWHONN has incorporated relevant content consistent with current literature and practice recommendations from a variety of sources, and from key AWHONN publications. In particular, content for this *Compendium* was adapted in part, from AWHONN's *Perinatal Nursing*, (4th Edition), and from relevant AWHONN evidence-based clinical practice guidelines. We acknowledge and are grateful for the expertise and work of the editors, contributors, and reviewers for those publications.

AWHONN honors the memory of Ms. Mary Ellen Boisvert, MSN, RN, CLC, CEE, whose review of this book represents only a small view of her untiring dedication and service to AWHONN. Mary Ellen's passion for her work, for life-long learning and professional growth, and for her unflinching commitment to AWHONN's mission, members, and her colleagues will be greatly missed.

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Preface

The *AWHONN Compendium of Postpartum Care* (3rd Edition) (*Compendium*), provides essential information for nurses caring for women, infants, and families in the hospital, birthing center, out-patient, and home settings. This revised reference book provides evidence-based information and guidelines for postpartum care, addressing the physical, developmental, emotional, and psychosocial needs of mothers, newborns and families from birth through the first postpartum visit. This third edition *Compendium* is reformatted by topic area for ease of access by the reader and includes the following chapters:

- Chapter 1: Assessment and Care of the Postpartum Woman
- Chapter 2: Assessment and Care of the Newborn
- Chapter 3: Infant Feeding
- Chapter 4: Maternal and Infant Discharge Planning, Health Teaching, and Early Homecare
- Chapter 5: Postpartum Mood and Anxiety Disorders

Most women experience normal healthy pregnancies, therefore, much of postpartum nursing care and discharge preparation focuses on meeting mothers' fundamental physical and psychosocial needs. However, maternal morbidity and mortality has emerged as a significant health care crisis in the United States. Each year, more than 700 women die from pregnancy-related causes, and the majority of these deaths occur during the postpartum period. The *Compendium* third edition includes expanded content on postpartum complications and highlights AWHONN's POST-BIRTH Warning Signs parent education.

Newborn care content includes updated evidence-based information for normal newborn care and discharge preparation, and a section focused on assessment and care of the late-preterm infant. A dedicated infant feeding chapter provides comprehensive, best practice information targeted to breastfeeding protection, promotion, and support. It also includes updated guidance on formula preparation, use, and storage for mothers who cannot, or make informed decisions not to breastfeed their newborns.

Postpartum mood and anxiety disorders present a significant threat to both maternal and infant health. Sadly, in extreme cases, these disorders can result in the death of the mother and her infant or her other children. The third edition features updated research and practice recommendations for the spectrum of postpartum mood and anxiety disorders, and includes a series of case examples that helps to bring the mother's view of these disorders into clear focus.

Teaching mothers how to care for themselves and their infants at home is a key nursing role in promoting continuity of care. Nurses caring for postpartum women help to ensure that these women connect with primary care providers, out-patient services, and community resources. Hospital-based nurses should be aware of relevant community resources, and nurses practicing in the community should be aware of best practices for continuing postpartum care and education when the mother and infant are discharged.

Each updated chapter includes a relevant case study and a resource list for further exploration by postpartum and mother-baby nurses, or to share with mothers during discharge preparation. Please visit AWHONN's *Healthy Mom and Baby* website to access a wide variety of patient education resources at https://www.health4mom.org/

As the Editors of this new edition of the *AWHONN Compendium of Postpartum Care*, our goal was to provide a comprehensive, user-friendly resource that has great value for all nurses who provide care for women during the postpartum period. We hope we have accomplished this goal for our readers.

Patricia D. Suplee, PhD, RNC–OB
Jill Janke, PhD, RN

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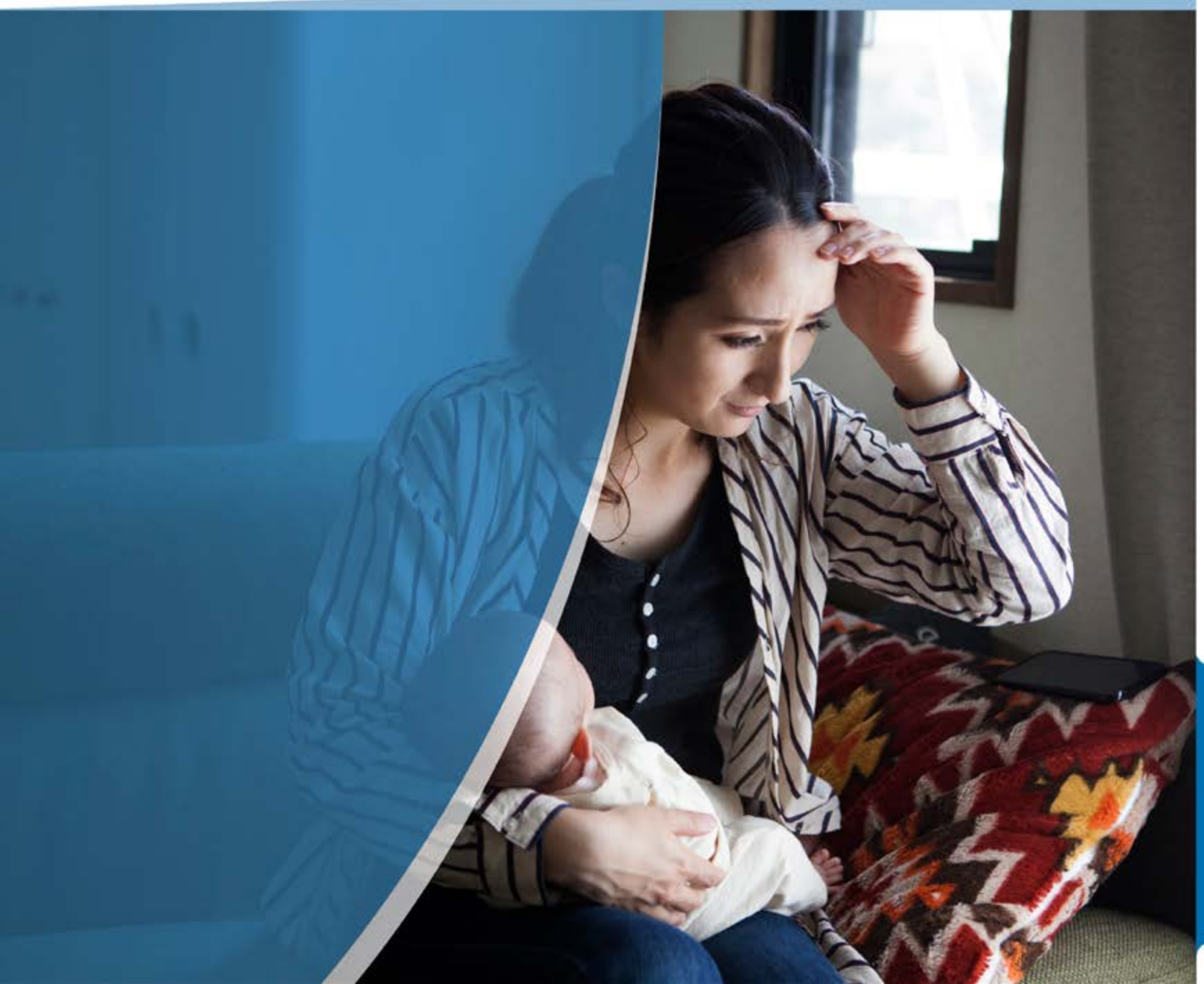
CHAPTER 5

Cheryl Tatano Beck, DNSc, CNM, FAAN

POSTPARTUM MOOD AND ANXIETY DISORDERS



Chapter 5
Postpartum Mood and Anxiety Disorders

The purpose of chapter five is to provide an overview of postpartum blues as well as to describe other forms of postpartum mental illness. Childbirth is one of the most powerful triggers of psychiatric illness during a woman's lifetime. The causes of postpartum psychiatric disorders are complex and typically involve an interaction of multiple factors, including biological, psychological, and social influences. In addition, genetic and environmental factors can increase the risk of such disorders. The mechanisms implicated in the etiology of postpartum psychiatric disorders are illustrated in Figure 5.1.

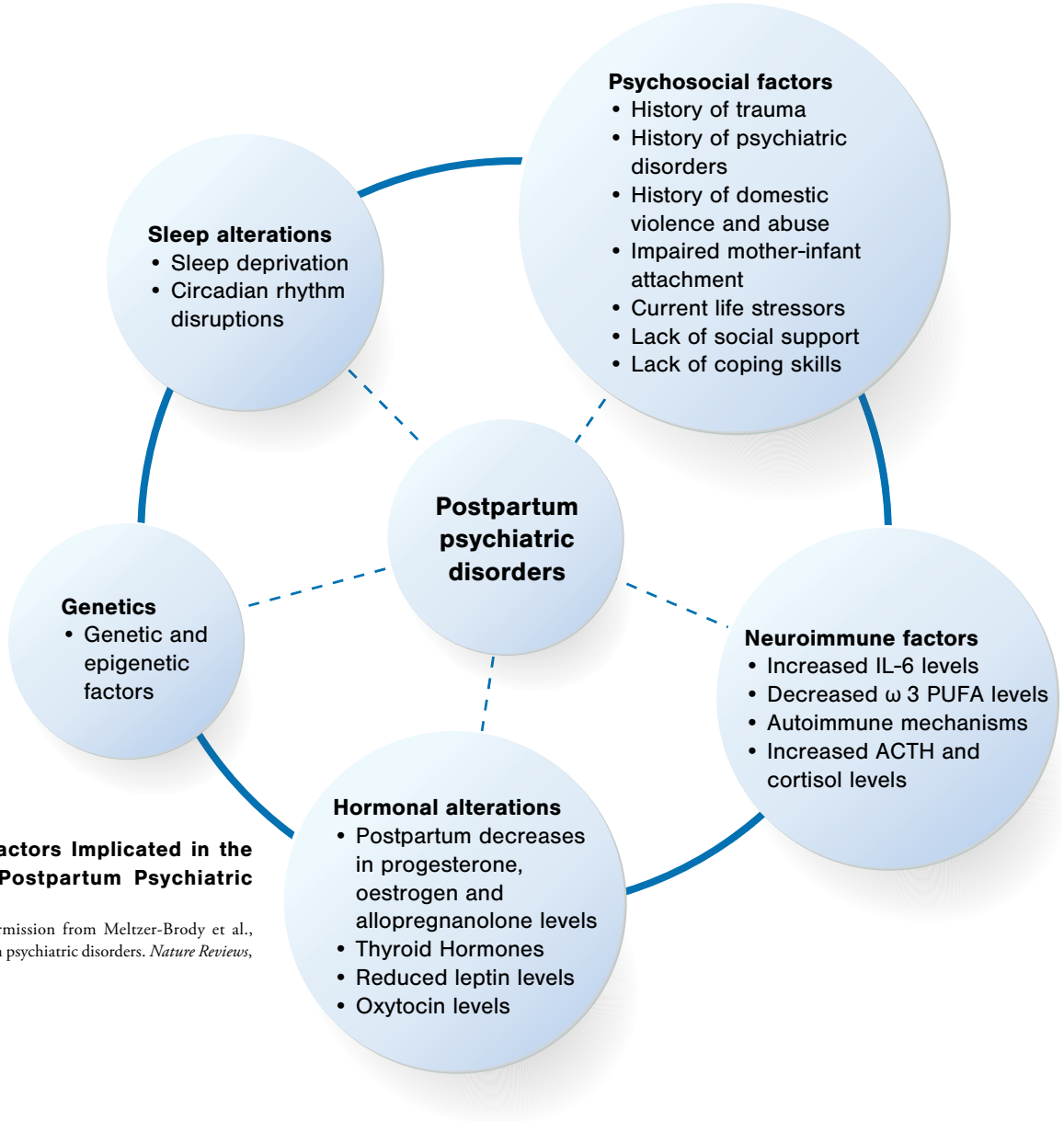


Figure 5.1 Factors Implicated in the Etiology of Postpartum Psychiatric Disorders
Reprinted with permission from Meltzer-Brody et al., (2018a). Postpartum psychiatric disorders. *Nature Reviews*, 4, p.4.

Although postpartum depression is the most well-known postpartum mental health disorder, women may develop other lesser-known disorders during the postpartum period (American Psychiatric Association [APA], 2013). It is important for postpartum nurses to learn how to differentiate postpartum blues from other mental health disorders that new mothers may experience. The purpose of the first section of this chapter is two-fold: to provide a description of postpartum blues and to introduce and help nurses distinguish among the following mental health disorders, based on the Diagnostic and Statistical Manual of Mental Disorders 5 (DSM-j):

- Major depressive disorder (with peripartum onset), more commonly referred to as postpartum depression
- Bipolar II disorder (with peripartum onset)
- Brief psychotic disorder (with postpartum onset), more commonly referred to as postpartum psychosis
- Obsessive-compulsive disorder
- Panic disorder
- Posttraumatic Stress Disorder (PTSD)

Postpartum Blues

Postpartum blues, also known as "baby blues," is usually a mild, transient condition that occurs during the first few days after childbirth and that lasts approximately ten days. One of the hallmarks of postpartum blues is emotional lability: women may experience abrupt mood swings, weepiness, "feeling let down," irritability, and over-sensitivity. Because no standardized criteria have been established, the prevalence rate is difficult to determine. As a result, postpartum blues has an estimated prevalence rate that ranges from 26% to 84%. Note: The term *prevalence* in general denotes the proportion of a population who have specific characteristics or conditions during a given time period. Prevalence estimates vary in individual studies due to the different instruments used to assess postpartum depression and in relationship the timeframe over which prevalence was determined.

According to Buttner, O'Hara, and Watson (2012), the abrupt drop in ovarian hormones (specifically estradiol and progesterone) occurring with the delivery of the placenta is thought to contribute to postpartum blues. Risk factors for more severe postpartum blues include relationship difficulties, a history of depression, and a history of premenstrual symptoms. Postpartum blues can be exacerbated by a number of issues, such as when a woman is insecure, over stimulated, fatigued, is in pain, or lacks a strong support system. It is appropriate for nurses to suggest the following comfort measures to help mothers minimize these exacerbations: sleeping when the baby sleeps; creating a quiet, calm environment; eating nutritious foods; controlling pain; accepting help when it is offered; ignoring chores; and focusing on themselves and their baby. Because postpartum blues is a self-limiting condition that does not interfere with the functioning of women, no active intervention is necessary, except for support and reassurance (Rai, Pathak, & Sharma, 2015).

The negative mood swings associated with postpartum blues tend to peak during days three to five, after which the condition gradually resolves (Kennerley & Gath, 1989). Thus, it is important for nurses to educate the woman and her family—before discharge—about the causes, signs and symptoms, coping methods, as well as about the self-limiting nature of the condition. Because the occurrence of postpartum blues is a risk factor for developing postpartum depression, a more serious disorder, families should know to seek medical attention in the event that the postpartum blues get worse or do not resolve.

Postpartum Depression

Major depressive disorder with peripartum onset is the official diagnosis for postpartum depression, according to the DSM-5. To make a diagnosis of postpartum depression, five or more of the following symptoms must be present for two weeks and result in a difference in the person's previous functioning. Commonly identified symptoms of major depressive disorder include significant weight loss, insomnia or hypersomnia, psychomotor retardation or agitation, fatigue, difficulty concentrating or making decisions, and suicidal thoughts (APA, 2013). One of the symptoms must be either:

- Depressed mood for the majority of the day, or
- Decreased interest or pleasure in most activities.

In the DSM-5, there is now a specifier called "with peripartum onset." To apply this specifier, the onset of symptoms must occur during pregnancy or during the first four weeks after giving birth. However, most clinicians and researchers consider the four-week postpartum cutoff to be too limited. The time frame is debatable, but most researchers use a period of up to three months after birth, and some researchers expand this time frame to twelve months postpartum (O'Hara & McCabe, 2013).

Gavin et al. (2005) conducted a quantitative review of the prevalence of postpartum depression during the first three months postpartum. In their findings, Gavin and colleagues reported a prevalence of diagnosed major depression of 7.1%, and a prevalence of both minor and major depression of 19.2%. Shorey et al. (2018) conducted a systematic review of prevalence and incidence rates of postpartum depression among healthy mothers without a history of depression. Note: The term *incidence* refers to the rate of new cases

per population at risk, in a given time period. Shorey et al. reported an incidence rate of 12% and an overall prevalence rate of 17%. When it came to regional differences, they found that the Middle East had the highest prevalence rate (26%) and Europe had the lowest prevalence rate (8%). In a meta-analysis of eight studies, the prevalence of a clinical diagnosis of comorbid anxiety and depression during the postpartum period was determined to be 4.2% (Falah-Hassani, Shiri, & Dennis, 2017).

Risk Factors for Postpartum Depression

Nurses should be familiar with common risk factors for postpartum depression. Three meta-analyses summarized the findings of studies that investigated predictors of postpartum depression (Beck, 2001; O'Hara & Swain, 1996; Robertson, Grace, Wallington, & Stewart, 2004). The following predictors of postpartum depression were identified:

- Prenatal depression
- Stressful life events
- Low social support
- Prenatal anxiety
- Poor marital satisfaction
- History of previous depression
- Low socioeconomic status

In addition, Vliegen, Casalin, and Luyten (2014) reviewed 17 longitudinal studies that examined risk factors of postpartum depression. They identified four categories of risk factors: partner relationships and social support; a history of mental health problems or more specific childhood features such as childhood sexual abuse; contextual risk factors of parental stress and financial worries; and personality factors, such as excessive self-criticism, anxiety regarding relationships, and an immature defense style. Further, researchers conducted three meta-analyses that confirmed intimate partner violence as an additional risk factor for postpartum depression (Beydoun, Kaufman, Lo, & Zonderman, 2012; Howard, Oram, Galley, Trevillion, & Feder, 2013; Wu, Chen, & Xu, 2012).

The prevalence and risk factors for postpartum depression among mothers with preterm and low-birth-weight infants were systematically reviewed in 26 studies for a total of 2,392 mothers of preterm infants (Vigod, Villegas, Dennis, & Ross, 2010). Symptom prevalence rates of postpartum depression were as high as 40% during the early postpartum period among mothers of preterm infants. Sustained elevated depressive symptoms that occurred over the first-year postpartum were associated with earlier gestational age, lower birth weight, continued infant illness, and perceived lack of social support.

Yim, Stapleton, Guardino, Hahn-Holbrook, and Schetter (2015) conducted a systematic review of the psychosocial predictors of postpartum depression. They identified 151 studies. Due to the great number of studies, the researchers focused their review on studies with the sounder methodologies. The stronger predictors of postpartum depression were severe life events, chronic strain (e.g., lack of job security, short family leave time, and low socioeconomic status), poor relationship quality, and low level of support from partners and mothers. Other risk factors for postpartum depression included domestic violence and preterm infants in the NICU. Table 5.1 summarizes the significant risk factors for postpartum depression and their references.

Table 5.1 Risk Factors for Postpartum Depression

Risk Factors	References
Prenatal depression	Beck, 2001; O'Hara & Swain, 1996; Robertson et al., 2004
Past history of depression or psychiatric problems	Beck, 2001; O'Hara & Swain, 1996; Robertson et al., 2004; Vliegen et al., 2014
Poor marital/partner relationship	Beck, 2001; O'Hara & Swain, 1996; Vliegen et al., 2014; Yim et al., 2015
Stressful life events	Beck, 2001; O'Hara & Swain, 1996; Robertson et al., 2004; Vliegen et al., 2014; Yim et al., 2015
Low social support	Beck, 2001; O'Hara & Swain, 1996; Robertson et al., 2004; Vliegenet al., 2014; Yim et al., 2015
Prenatal anxiety	Beck, 2001; O'Hara & Swain, 1996; Robertson et al., 2004
Low socioeconomic status/financial worries	Beck, 2001; O'Hara & Swain, 1996; Vliegen et al., 2014
Intimate partner violence	Beydoun et al., 2012; Howard et al., 2013; Wu et al., 2012; Yim et al., 2015
Preterm and low birth weight infants	Vigod et al., 2010; Yim et al., 2015
Personality factors: excessive self-criticism, anxiety regarding relationships, and immature defense style.	Vliegen et al., 2014

Stages of Postpartum Depression

It is important for nurses to understand the stages of postpartum depression. Beck (1993) reported that women suffering from postpartum depression moved through a four-stage process, which the author titled "Teetering on the Edge", as shown in Figure 5.2. Beck identified the stages as follows: Stage 1, Encountering Terror; Stage 2, Dying of Self; Stage 3, Struggling to Survive; and Stage 4, Regaining Control. The primary problem recounted by women suffering from postpartum depression was a loss of control over their emotions, over their thought processes, and over their actions (Beck, 1993).

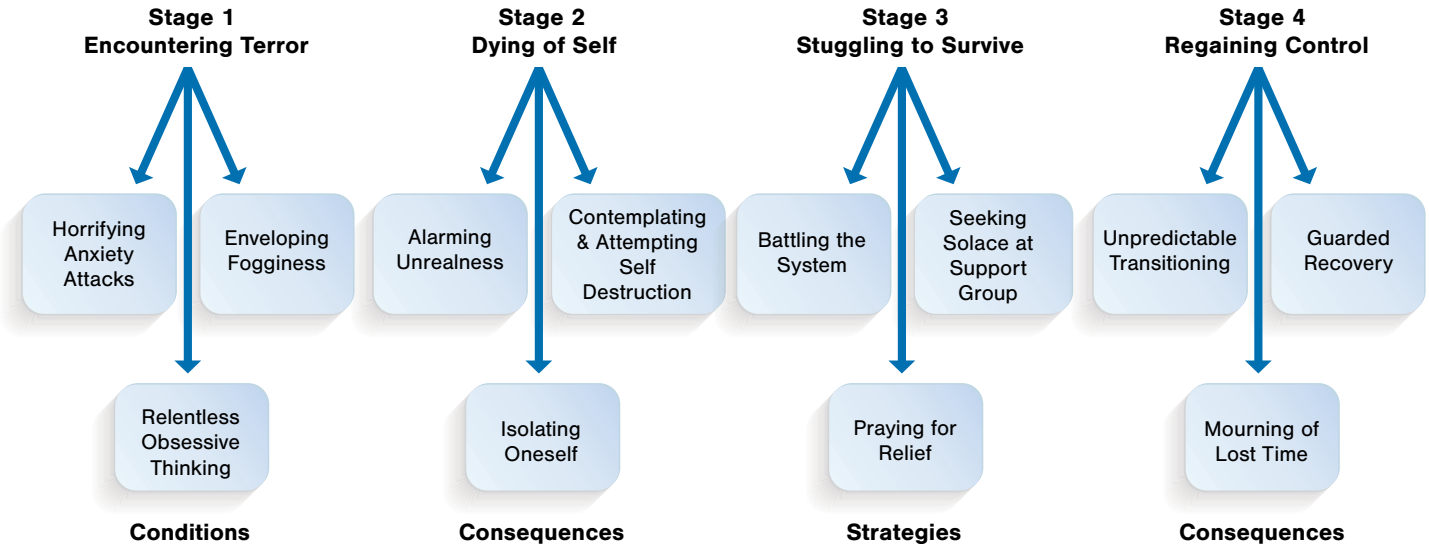


Figure 5.2 The Four-Stage Process of Teetering on the Edge
Reprinted with permission from Beck, C.T. (1993). Teetering on the Edge: A Substantive Theory of Postpartum Depression. *Nursing Research*, 42, 42-43.

Stage 1: Encountering terror. Mothers described this initial stage as a terrifying onslaught of horrifying anxiety, relentless, obsessive thinking, and enveloping fogginess.

Horrifying anxiety. When suffering an anxiety attack, women felt they were "losing their minds," and some believed they were dying. One mother described her experience in the following terms:

> When it first hit me at seven months, I had a major anxiety attack. It came out of the blue. I just felt numb all over, and I started to hyperventilate. I felt this pain in my chest, so I started to think, Oh my God. I'm having a heart attack. I'm dying! It was like every nerve in my body was exploding. Like little fireworks were going off all over my body. I felt like I was going crazy (Beck, 1993, p. 45).

The anxiety experienced by some mothers did not emerge in the form of an attack, rather, it progressed in a more insidious manner that permeated their day-to-day activities.

Relentless obsessive thinking. The loss of control that women experienced also affected their thought processes. Mothers were constantly bombarded with obsessive thoughts that they were unable to stop, no matter how hard that they tried.

Enveloping fogginess. Mothers repeatedly used the image of fog rolling-in to capture the cognitive impairment they experienced. Loss of concentration was also described by some mothers. The loss of concentration was so significant for some women that they could not concentrate long enough to read a page of a book. In addition to the inability to concentrate, some women described periods of irrational thinking during their depression.

Stage 2: Dying of self. As a consequence of the conditions in the previous stage, during the second stage, the "dying" of women's normal selves followed. Such dying consisted of three consequences: alarming "unrealness," isolating oneself, and contemplating and attempting self-destruction.

Alarming unrealness. Women's normal selves were no longer present. Mothers did not recognize the person who they had become. They repeatedly reported that they did not feel real, but instead, they felt like robots that were simply going through the motions of childcare. Any caring emotions or joy were missing from their lives.

Isolating oneself. Mothers felt all alone because they believed that no one really understood the living nightmare that they were going through. Women lost all interest in their usual activities and goals.

Contemplating and attempting self-destruction. Not only were some mothers pondering death, but a small percentage attempted to take their own lives.

Stage 3: Struggling to survive. In this third stage, mothers employed three different strategies: battling the system, praying for relief, and seeking solace in a postpartum depression support group.

Battling the system. This stage refers to the disappointment, frustration, humiliation, and anger that mothers experienced as they began to seek professional help. Finding appropriate treatment was not an easy task. For some women, this quest followed a "torturous path" (Beck, 1993, p. 46). Among mothers who found an appropriate health care professional, some of those diagnosed with postpartum depression still grappled with the reality of their situation. They struggled to accept the necessity of their being admitted to a psychiatric hospital, and, in some cases, their requiring electroshock therapy when antidepressants did not successfully treat their depression.

Praying for relief. Some women turned to prayer to help them survive. Women said that their god, regardless of their religious affiliation, truly helped them get through their ordeal.

Seeking solace in a support group. Support from others led to many valuable benefits for women. Being with other mothers suffering from the same mood disorder helped to counter the isolation and feelings of loneliness. At support group meetings, some mothers who had recovered from postpartum depression returned to help those women who were still struggling with this illness. Their presence provided hope to these mothers that they too could overcome this depression and regain control of their lives.

Stage 4: Regaining control. In this final stage of *teetering on the edge*, mothers experienced three consequences: unpredictable transitioning, mourning lost time, and guarded recovery.

Unpredictable transitioning. As their depression slowly lifted, mothers encountered a very unpredictable process. They experienced "good days" and "bad days," but when they woke up in the morning, they did not know which kind of a day it would be. Gradually, the number of good days outnumbered the bad days.

Mourning lost time. This phenomenon occurred as mothers progressed through their recovery from postpartum depression. Mothers grieved the lost time that they would never recapture with their infants. One mother said, "I felt robbed of the first six months of my daughter's life. I never really got to hold her as a baby, and I feel cheated" (Beck, 1993, p. 47).

Guarded recovery. Mothers felt they had essentially recovered from their depression. However, they cautioned, that postpartum depression had left an indelible mark on their lives. Mothers felt fragile after fighting their battle with this mood disorder. One mother attempted to explain her experience:

> Postpartum depression makes you feel very, very vulnerable. You still feel like you're on a fine line between sanity and insanity because when it first happened, it came out of nowhere. You're normal and then the next thing you know you're crazy (Beck, 1993, p.47).

Experiences of Mothers with Postpartum Depression

In 2002, Beck conducted a meta-synthesis of qualitative studies on postpartum depression that provided nurses with additional insight into the experiences of mothers who are suffering from this disorder. Beck identified four overarching themes in this meta-synthesis: incongruity between expectations and the reality of motherhood; spiraling downward; pervasive loss; and making gains, as shown in Figure 5.3. In the first theme, incongruity between expectations and the reality, women succumbed to the dangerous myth of equating motherhood with total fulfillment and happiness; in so doing, they set expectations that were impossible to attain. As a result, women became disillusioned with motherhood, and perceived that they failed to fulfill their dreams of being the perfect mother.

Consequently, such women felt a sense of spiraling downward. According to this theme, mothers experienced a range of distressing emotions, beyond simply sadness and depression. These included anxiety, anger, feeling overwhelmed, loneliness, isolation, guilt, suicidal thoughts, and other troubling emotions. Feeling scared was also recounted by some women, leading to intrusive thoughts of harming their baby, which then progressed into fears that they may actually act on their impulses. One mother described her feelings in these terms:

> Originally it had been about all kinds of horrific ways of hurting her…I could hardly bear to look at like the creases on her neck, and I'd imagine someone cutting them with a razor blade. I couldn't stop them, but think it was just stabbing her in the stomach, it just changed to that, stabbing her in the stomach all the time…then the things became more like urges to hurt her, and that really scared me. That shook me up, you know? It felt like in the very kind of marrow of my being, the very depths of my soul (Semprevivo, 1996, p. 86).

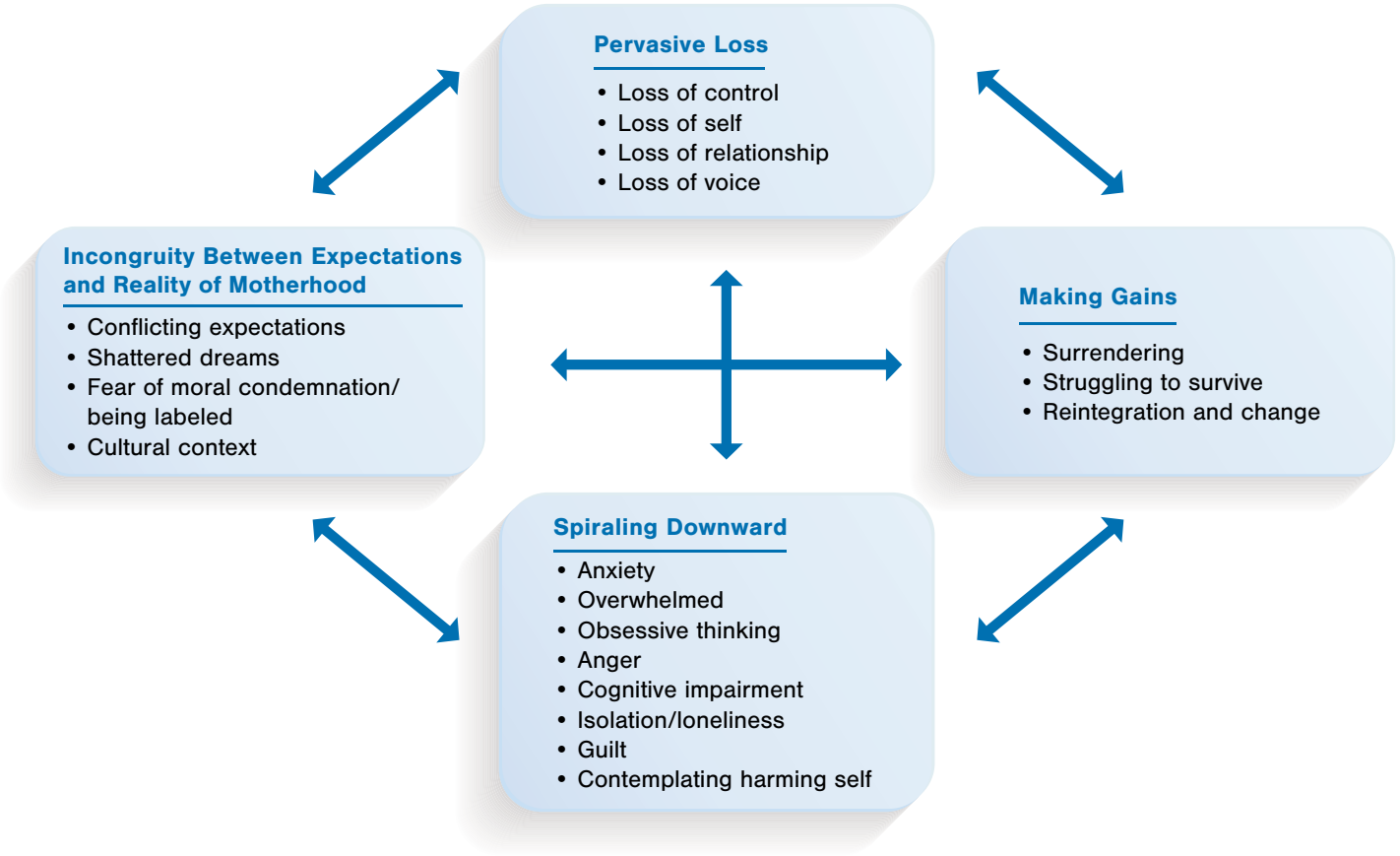


Figure 5.3 Four Perspectives Involved with Postpartum Depression
Reprinted with permission from Beck, C.T. (2002). Postpartum depression: A metasynthesis, *Qualitative Health Research, 12,* p.461.

Pervasive loss was the third theme in this meta-synthesis. Examples of this theme included loss of control of their thoughts and emotions, loss of self, loss of meaningful relationships, and loss of their voice. Mothers attempted to explain the loss of the person who they once were and the loss of their former selves. Relationships with their partners, their babies, their older children, their families and friends changed. These mothers made an active and conscious decision to silence their own voices by not discussing their feelings. They did this for several reasons, such as fear of burdening their loves ones, fear of their baby being taken away, and feelings of shame and embarrassment. One mother recounted that she felt "imprisoned in my own prison…the depression was like having sand banks on each door, and even though I knew I could open them and walk out, I didn't" (Mauthner, 1998, p.345). In her case, she had purposely decided not to disclose the anguish caused by her postpartum depression.

As women's depression began to lift, the fourth theme, making gains, came into play. Making gains was the beginning of the healing process. Surrendering embodied the first part of this process, meaning that women recognized that something was very wrong, and that they needed to seek help. Some women struggled on their difficult road to recovery, particularly when their cries for help were ignored or minimized. Prayer and support groups were helpful survival strategies for many women. As their depression lifted, women shifted the unrealistic expectations that they had imposed on themselves as mothers, partners, and family members. This shifting was necessary as they rebuilt themselves.

Effects of Postpartum Depression on Families

Perinatal nurses should understand the far-reaching effects of postpartum depression. The condition can have consequences beyond the personal suffering of the mothers, such as disturbing mother-infant relationships and impairing cognitive and emotional development of the children. In addition, the relationship between the father and mother may be strained. Sometimes, fathers can also develop postpartum depression (Paulson & Bazemore, 2010).

Effect of postpartum depression on the mother-infant relationship. Field (2010) reviewed quantitative studies from the prior decade on the effects of postpartum depression on mother-infant interactions. Mothers with this mood disorder tended to use two different styles of

interacting with their infants: intrusive and over-stimulating or withdrawn and under-stimulating. Field concluded that "the interaction disturbances of depressed mothers and their infants appear to be universal across differing cultures and socioeconomic status groups and include less sensitivity of the mothers and responsivity of the infants" (p.1).

The descriptions mothers shared also revealed the nature of their struggles in caring for their children during the depths of their depression (Beck, 1996). Beck's phenomenological study with twelve mothers provided a vivid picture of their experiences when interacting with their infants and older children. Women expressed feeling haunted by guilt and worry regarding the possible effects that their depression could have on their children. One mother recounted:

> I remember when she was about six months old holding her in my psychiatrist's office. I had started to cry, and my psychiatrist noticed it. [The baby] reached up and stroked my face, and that made me very happy but also very sad and guilty, cause I really didn't think that she should have to feel responsible for comforting me, and it became very clear it was really a big burden to put on kids if they have to feel they have that kind of responsibility (Beck, 1996, p. 102).

Always striving to minimize the negative effects that their postpartum depression might have on their children, mothers attempted to put their children's needs above their own, as the following passage illustrates:

> I thought about [taking] a razor blade to my wrists every day during the worst of my depression; well, if it weren't for my son - you see, my maternal instincts never left. I felt like, God, this poor child growing up knowing his mother killed herself because of him. That was the biggest thing that kept me from doing it (Beck, 1996, pp. 102-103).

Effect of postpartum depression on child development. Longitudinal research has been conducted that confirms the association between a mother's postpartum depression and the cognitive, emotional, and behavioral adjustment problems in her children. In O'Hara and McCabe's (2013) systematic review, they reported that postpartum depression predicted poor language skills and low IQ development in children across the childhood years and into adolescence. This effect was more pronounced in boys than in girls. Liu et al. (2017) conducted a meta-analysis of 14 studies on maternal depressive symptoms and early childhood cognitive development. Their analysis revealed that maternal depressive symptoms were significantly related to lower cognitive scores in children less than 56 months of age. In one of the longest prospective longitudinal studies comparing children of mothers who were depressed postpartum and children whose mothers were not depressed postpartum, Murray et al. (2011) reported on the developmental risk pathway of children up to 16 years of age. The children of mothers with postpartum depression showed greater incidence of insecure attachment in infancy, depressive cognition at five years of age, anxiety by 13 years of age, and greater incidence of depression by 16 years old when compared to children whose mothers had not suffered from postpartum depression.

Effect of postpartum depression on fathers. Fathers are an essential part of the parental triad in promoting the growth and development of their children. If mothers are struggling with postpartum depression, fathers can buffer their children from some of the negative effects of the mother's mood disorder. Fathers also can play a significant role in supporting their partners who are depressed after birth. If, however, fathers are also depressed, this complication compounds the family's difficulties (Paulson & Brazemore, 2010).

In their meta-analysis of postpartum depression in fathers, Paulson and Bazemore (2010) reported an average prevalence rate of 14.1% from U.S. studies, and they reported that international studies averaged a rate of 8.2%. Edward, Castle, Mills, Davis, and Casey (2015) conducted an integrative review of paternal depression from 63 studies. They found that paternal postpartum depression was associated with a personal history of depression and with depression in their partner during pregnancy and after birth. The prevalence of paternal depression in the postpartum period was also examined in a meta-analysis by Cameron, Sedov, and Tomfohr-Madsen (2016). At 0-3 months postpartum, the range was 6.3 to 9.7%. Prevalence rates were higher during the 3-6 months postpartum period and ranged from 7.2% to 22.3%. A significant predictor of paternal depression rates in the postpartum period was maternal depression. Little has been published about routine screening and referral of fathers during the postpartum period. Postpartum nurses can help to educate families about the possibility of postpartum depression in fathers as well as in mothers.

Treatment of Postpartum Depression

Nurses should have a working knowledge of the treatment options for postpartum depression, so that they can assist in reassuring the mother and her family that she can be helped. Treatment for postpartum depression can be categorized by type of intervention and includes the following: psychological, psychosocial, pharmacological, and complementary and alternative therapies. Offering a variety of

treatments may help a woman's acceptance of the intervention, as she can match her personal preference for treatment types, especially while she is breastfeeding.

Psychological interventions. Two main types of psychological interventions are interpersonal psychotherapy (IPT) and cognitive behavioral therapy (CBT). IPT is a time-limited interpersonally-focused psychotherapy, based on the belief that individuals who are experiencing social disruptions are at increased risk of developing depression (Stuart & O'Hara, 1995). An individual's interpersonal relationships are the primary focus of IPT. Patients work with mental health care providers to modify either a relationship or to modify their expectations regarding the relationship. Women with postpartum depression are treated by helping them to concentrate on four interpersonal problem areas: role transitions, interpersonal disputes, grief, and interpersonal deficits. After an assessment is completed, the mother and therapist select a specific problem area on which to work.

Specific IPT techniques for postpartum depression include psychoeducation, communication analysis, and role-playing (Stuart & O'Hara, 1995). In psychoeducation, the therapist not only provides information about postpartum depression but also about child development and care. Communication analysis is used to help discuss a particular incident in an interpersonal dispute. The therapist helps the mother identify the manner in which communication may have been ambiguous and misleading. In addition, role-playing is used to help women gain insight into their interactions with their partners. Sockol (2018) conducted a systematic review and meta-analysis of IPT for women with postpartum depression. Seventeen studies were included, and Sockol concluded that IPT is an effective intervention for mothers who experience elevated depressive symptoms during the first year postpartum.

CBT, the second main psychological treatment approach for postpartum depression, is a type of psychotherapy that focuses on increasing cognitive and social skills, evaluating and modifying dysfunctional thought patterns, encouraging self-reinforcement, and developing positive coping statements and problem-solving skills. CBT is a short-term psychotherapy that focuses on identifying and challenging distorted thinking as it helps mothers learn skills and techniques to modify their negative patterns of behavior (Beck & Beck, 2011).

A meta-analysis was conducted of nine NICU-based randomized controlled interventions to decrease maternal depressive symptoms (Mendelson, Cluxton-Keller, Vullo, Tandon, & Noazin, 2017). Types of interventions included CBT, educational approaches, and maternal-infant responsiveness training. When the effects of different interventional approaches were compared, it was found that CBT was associated with a significant improvement in depressive symptoms in mothers; however, combinations of education-based approaches were not associated with improvement.

Psychosocial interventions. Psychosocial interventions are often based on the significant psychosocial variables identified as risk factors for postpartum depression. Examples of psychosocial interventions include peer support, home visits by mental health nurses, partner support, and non-directive counseling, also called "listening visits." Dennis (2014) reviewed 13 trials of psychosocial interventions for the treatment of postpartum depression. Due to the methodological limitations of these studies, Dennis concluded that the effectiveness of these treatments was equivocal. Further, Dennis (2014) recommended the necessity for large, multisite randomized control trials to examine the effectiveness of individual psychosocial interventions.

Dennis and Dowswell (2013) conducted a Cochrane database systematic review of 28 trials of psychosocial and psychological interventions for preventing postpartum depression. Overall, women who received either a psychological or a psychosocial intervention were significantly less likely to develop postpartum depression in comparison to women who received standard care. Dennis and Dowswell (2013) identified several promising interventions: postpartum home visits by nurses or midwives, lay (peer) based telephone support, and IPT.

The U. S. Preventive Services Task Force (USPSTF) published their recommendation statement regarding interventions to prevent perinatal depression. After reviewing the evidence, the USPSTF concluded that counseling interventions, such as CBT and IPT, were effective in preventing perinatal depression (USPSTF, 2019).

Pharmacological interventions. Pharmacological interventions include several classes of antidepressants for the treatment of postpartum depression. Serotonin plays a critical role in mood and emotional stability. Selective serotonin reuptake inhibitors (SSRIs) are considered the first-line pharmacologic treatment for postpartum depression, after the diagnosis of bipolar disorder has been ruled out (Kim, Epperson. Weiss, & Wisner, 2014). An example of an SSRI is sertraline. Tricyclic antidepressants are the second class of antidepressants used to treat postpartum depression. Examples of this class of antidepressants include desipramine and nortriptyline.

Molyneaux, Howard, McGeown, Karia, and Trevillion (2014) conducted a meta-analysis of antidepressant treatment for postpartum depression. They found that SSRIs were significantly more effective than placebo. These authors cautioned that the conclusions were tentative due to small samples and risk of bias. Women should be advised that it can take up to 4 weeks before full therapeutic effects of

SSRIs are achieved. The length of time mothers should be treated with antidepressants is not definite.

The first drug developed specifically for the treatment of postpartum depression, brexanolone, was recently tested in two double-blind, randomized placebo-controlled trials (Meltzer-Brody et al., 2018b). It is administered as a continuous intravenous infusion over 2.5 days, under medical supervision. In early studies of the drug, it was found that 50% of the women were no longer clinically depressed within 60 hours of infusion. Effects appeared to last at least 30 days, which permitted caregivers to start other treatments during that time. Serious side effects can include excessive sedation with a sudden loss of consciousness.

When treating postpartum mood and anxiety disorders, clinicians should weigh the risk and benefits of psychopharmacology with the benefits of breastfeeding—for both the mother and her infant—versus no treatment. Clinicians can find excellent websites for guidance in the selection of medications and in the safety of medications for breastfeeding mothers. An online version of Thomas Hale's classic work on medications and breastfeeding, Medications and Mothers' Milk (2019) is also available (www.medsmilk.com). Additional online resources for breastfeeding and medications include the Massachusetts General Hospital Center for Women's Mental Health (www.womensmentalhealth.org) and the Motherisk Program in Toronto, Canada (www.motherisk.org). Further, a website (www.toxnet.nlm.nih.gov) containing the Developmental and Reproductive Toxicology Database, sometimes called LactMed, features a medication search for various drugs as they relate to the pregnancy and postpartum periods. Other resources include Texas Tech Infant Risk (www.infantrisk.com) and Repro Tox (www.reprotox.org).

Complementary and alternative medicine. For women who prefer not to take antidepressants, complementary and alternative medicine therapies are options. Some of these more commonly used therapies include supplementation with omega-3 fatty acids, massage therapy, exercise, and acupuncture. The role of diet and nutritional supplementation in perinatal depression was reviewed by Sparling, Henschke, Nesbitt, and Gabrysch (2017). Inconsistencies across studies and methodological limitations of existing studies with vitamins B and D and omega-3 fatty acids prevented a conclusive determination regarding whether nutritional factors influenced postpartum depressive symptoms. In a meta-analysis of 16 trials, McCurdy, Boulé, Sivak, and Davenport (2017) examined the effect of exercise during the postpartum period on mild to moderate depressive symptoms. Such interventions primarily included aerobic exercise. Exercise had a small, significant effect in improving postpartum depression. In some cases, complementary and alternative treatments can be used to augment first-line therapies.

Screening for Postpartum Depression

One of the greatest obstacles to diagnosing postpartum depression is the failure of health care professionals to question new mothers about affective symptoms during the postpartum period. Despite multiple contacts with clinicians during the postpartum period, many women are not diagnosed with their postpartum mood disorder, and as a result, they go without much-needed treatment. One red flag for postpartum mood and anxiety disorders can be a woman who makes frequent calls and visits to health care providers after giving birth. Other diagnostic barriers for health care providers include insufficient training and lack of knowledge, lack of time, and lack of referral sources for follow-up of postpartum mood and anxiety disorders (Gjerdingen & Yawn, 2007).

Maternal suicide is a leading cause of death during pregnancy and the first year after giving birth. Palladino, Singh, Campbell, Flynn, and Gold (2011) analyzed violent maternal deaths in the United States, using data from the Centers for Disease Control and Prevention. Pregnancy-associated (occurring during pregnancy or the first year postpartum) suicide rate was 2.0 per 100,000 live births (N = 94). Of these suicides, 45.7% occurred during pregnancy and 54.3% during the postpartum period. In their study of Canadian maternal suicide, Grigoriadis et al. (2017) reported similar rates of perinatal suicide (2.58 per 100,000 live births). The majority of such suicides occurred during the final quarter of the first year after giving birth. Further, perinatal women were more likely to commit suicide using violent methods, such as hanging or jumping rather than nonviolent methods, such as an overdose (Oates, 2003). Given that suicide typically occurs throughout the first year postpartum, health care providers should be vigilant in assessing risk.

Currently, two instruments are available to screen women for postpartum depression: The Postpartum Depression Screening Scale (PDSS) from Beck and Gable (2002) and the Edinburgh Postnatal Depression Scale (EPDS) from Cox, Holden, & Sagovsky (1987). Clinicians should bear in mind that, because there is a comorbidity between postpartum depression and PTSD after childbirth, that when a mother screens positive for postpartum depression, she should be engaged in a dialogue about her previous births. Asking the mother questions, for instance, whether she "perceives her prior birth(s) as traumatic" is a simple screening measure. A mother who answers "yes" to this question may be suffering from PTSD.

In 2013, the Agency for Healthcare Research and Quality (AHRQ) published a report that reviewed the efficacy and safety of screening for postpartum depression in 40 studies. Multiple studies that included estimates for both sensitivity and specificity were available for only two screening scales: the PDSS and EPDS. Note: *Sensitivity* referred

Table 5.2 Postpartum Depression Screening Scale: Selected Items by Dimension

Directions: Below is a list of statements describing how a mother may be feeling after the birth of her baby. Please indicate how much you agree or disagree with each statement. Please circle the answer that best describes how you have felt over the past 2 weeks.

Sleeping/Eating Disturbances
- I had trouble sleeping even when my baby was asleep.
- I lost my appetite.

Loss of Self
- I did not know who I was anymore.
- I was afraid that I would never be my normal self again.

Anxiety/Insecurity
- I felt all alone.
- I felt really overwhelmed.

Guilt/Shame
- I felt guilty because I could not feel as much love for my baby as I should.
- I felt like I had to hide what I was thinking or feeling toward the baby.

Emotional Lability
- I felt like my emotions were on a roller coaster.
- I felt full of anger ready to explode.

Mental Confusion
- I could not concentrate on anything.
- I felt like I was losing my mind.

Suicidal Thoughts
- I started thinking I would be better off dead.
- I felt that my baby would be better off without me.

to the ability of the scales to correctly identify all screened women who had postpartum depression. *Specificity,* on the other hand, referred to the ability of the scales to correctly identify women who did not have postpartum depression. Sensitivity and specificity for both instruments were determined to be very good, in the 80-90% range, and no substantial differences between scales were noted. Referral and treatment rates for mothers who screened positive for postpartum depression were substantially higher in studies where the screening, diagnostic interview, and treatment were all provided in the same setting. The authors of the AHRQ report concluded that the "potential effectiveness of screening for postpartum depression appears to be related to the availability of systems to ensure adequate follow-up of women with positive results" (Myers et al., 2013, p. ix).

Postpartum depression screening scale (PDSS). The PDSS is a 35-item self-report scale developed to assess the presence, severity, and type of postpartum depressive symptoms. Table 5.2 illustrates the screening scale (Beck & Gable, 2002). The assessment tool is published and distributed by Western Psychological Services (www.wpspublish.com). The purpose of the PDSS is not to diagnose, but rather to identify mothers who have a high probability of suffering from postpartum depression. Written at a third-grade reading level, the PDSS contains statements about how a mother may be feeling after the birth of her infant. A 5-point Likert response format (1=strongly disagree, to 5=strongly agree) is used. All 35 items are negatively worded, so agreement with the item indicates endorsement of the depressive symptoms. Higher PDSS scores indicate higher levels of postpartum depressive symptoms.

The PDSS yields a total score, indicative of the overall severity of postpartum depressive symptoms. The scale consists of seven symptom content subscales: Sleeping/Eating Disturbances, Loss of Self, Anxiety/Insecurity, Guilt/Shame, Emotional Lability, Mental Confusion, and Suicidal Thoughts, with five items per subscale. All items were developed from Beck's series (1992, 1993, 1996) of qualitative studies on postpartum depression. The PDSS total score has a possible range of from 35 to 175. A cutoff score of 80 or above is considered a positive screen for a high probability

of major postpartum depression. This cutoff score yielded a sensitivity of 94% and specificity of 98% (Beck & Gable, 2002). Women who score in this range require psychiatric evaluation and should be promptly referred to a mental health team for follow-up and possible treatment.

When a woman scores a positive screen on the PDSS, clinicians should examine the scores for the subscales in order to identify a pattern of symptoms for that specific mother. As with the Total PDSS score, Beck and Gable (2002) have determined cutoff scores for each of the seven subscales. Beck and Gable compared the performance of the PDSS with the EPDS in a sample of 150 new mothers approximately six weeks after delivery. When identifying women with major postpartum depression, the PDSS had a sensitivity of 94% and specificity of 98% and the EPDS yielded a sensitivity of 78% and specificity of 99%.

Edinburgh postnatal depression scale (EPDS). The EPDS is a self-report questionnaire (Cox et al., 1987), consisting of 10 short statements of common depressive symptoms with four replies to each statement, as shown in Table 5.3. The mother chooses the response that best describes the way she has felt over the past seven days. Each statement is rated on a scale of 0–3, with possible total scores ranging from 0 to 30. The symptoms assessed in the EPDS include the following: inability to laugh; inability to look forward to things with enjoyment; blaming oneself unnecessarily; feeling anxious or worried; feeling scared or panicky; feeling that things have been "getting on top of me"; difficulty sleeping because of unhappiness; feeling sad or miserable; crying; and thoughts of harming oneself. The EPDS has achieved a sensitivity of 86% and specificity of 78% with cutoff scores of 12 or 13. A comparison of the PDSS and the EPDS is shown in Table 5.4.

Table 5.3 Edinburgh Postnatal Depression Scale (EPDS)

The questionnaire below is called the Edinburgh Postnatal Depression Scale (EDPS). The EDPS was developed to identify women who may have postpartum depression**.** Each answer is given a score of 0 to 3. The maximum score is 30.

Directions: Please select the answer that comes closest to how you have felt 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 haven't 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

TOTAL SCORE:
Scoring: Questions 1, 2, & 4 are scores 0, 1, 2, 3 with the top box scored as 0 and the bottom box as 3
Questions 3, and 5-10 are reverse scored, with the top box scored as 3 and the bottom box as 0
Retrieved from: http://perinatology.com/calculators/Edinburgh Depression Scale.htm; https://www.fresno.ucsf.edu/pediatrics/downloads/edinburghscale.pdf

Cox, J. L., Holden, J. M., & Sagovsky, R. (1987). Detection of postnatal depression. Development of the 10-item Edinburgh Postnatal Depression Scale. *The British Journal of Psychiatry : The Journal of Mental Science*, 150, 782-6.

Table 5.4 Screening Scales Specifically for Postpartum Depression

Screening Scale	Total number of items	Subscales	Time to administer in minutes	Total score range	Sensitivity	Specificity	Total cut off score	Reliability
Edinburgh Postnatal Depression Scale*	10	Not Applicable	>5	0-30	86	78	12/13	.87
Postpartum Depression Screening Scale (PDSS)**	35	• Sleeping/eating disturbances • Loss of self • Anxiety/insecurity • Guilt/shame • Emotional lability • Mental confusion • Suicidal thoughts	5-10	35-175	94	98	80	.96

* Cox, Holden, & Sagovsky (1987)
** Beck & Gable (2002)

Several organizations have recommendations or position statements regarding screening for postpartum depression. AWHONN (2015) recommends that all pregnant and postpartum women be screened for mood and anxiety disorders. Likewise, the American College of Obstetricians and Gynecologists (ACOG Committee on Obstetric Practice, 2018) recommends that obstetricians and gynecologists complete a full assessment of patient mood and emotional well-being—including postpartum depression and anxiety—during a postpartum visit. The American Academy of Pediatrics recommends that routine screening for postpartum depression be integrated into well-child visits at 1, 2, 4, and 6 months of age (Earls et al., 2019). Screening for all pregnant and postpartum women is also a recommendation from the USPSTF (2019).

There is no universal agreement on the best times to screen for postpartum depression. Because symptoms of postpartum depression frequently do not begin before discharge, screening during the hospital stay may not be optimal. Before discharge then, nurses should concentrate on providing anticipatory guidance to the mother and her family regarding symptoms of postpartum depression and the steps to take if such symptoms emerge (Beck & Driscoll, 2006).

Postpartum depression predictors inventory-revised (PDPI-Revised). The purpose of the PDPI-Revised (Beck, Records, & Rice, 2006) is to help identify women at risk for developing postpartum depression. The items in this inventory are based on the 13 postpartum depression risk factors identified in Beck's 2001 meta-analysis. These risk factors include:

- single marital status
- low socioeconomic status
- low self-esteem
- prenatal depression
- prenatal anxiety
- unplanned or unwanted pregnancy
- history of previous depression
- low social support
- poor marital satisfaction
- life stress
- childcare stress
- infant temperament
- maternity blues.

The PDPI-Revised can be used during prenatal and postpartum periods to target women who are at risk. During pregnancy, the first ten predictors can be assessed (Prenatal Version). After a mother has given birth, the last three risk factors, including childcare stress, infant temperament, and maternity blues, can also be assessed (Postpartum Version). The PDPI-R administered at one month after delivery accurately predicted 83.4% of postpartum depression diagnoses (Oppo et al., 2009). The PDPI-Revised can be used during an interview, or women may also complete the inventory themselves. Listed in Table 5.5 are guide questions and scoring directions for each risk factor on the PDPI-Revised that a nurse or other health care provider can use during the interview process. These guide questions can help clinicians determine whether or not each predictor applies to the mother being interviewed.

Table 5.5 Postpartum Depression Screening Scale: Selected Items by Dimension

INSTRUCTIONS: Scored items that are bolded in the first column are risk factor categories for postpartum depression. Scores are added up, with higher scores indicating greater risk. When a woman scores above the recommended cutoff of 10.5 on the Prenatal Version, she should be followed closely after delivery to determine if she is developing signs of postpartum depression.

PRENATAL VERSION	ASSIGNING SCORES
Marital Status	
Single, Married, Separated, Divorced, Widowed, Partnered	Married/partnered = 0; All single status = 1
Socioeconomic Status	
Low, Middle, High	Middle or High = 0; Low=1
Self Esteem	
Do you feel good about yourself?	Yes = 0; No = 1
Do you feel worthwhile?	Yes = 0; No = 1
Do you have good qualities?	Yes = 0; No = 1
Prenatal Depression	
Have you felt depressed during your pregnancy?	No = 0; Yes = 1
Prenatal Anxiety	
Have you been feeling anxious during your pregnancy?	No = 0; Yes = 1
Unplanned/unwanted pregnancy	
Was the pregnancy planned?	Yes = 0; No = 1
Was the pregnancy unwanted?	No = 0; Yes =1
History of Previous Depression	
Before this pregnancy, have you ever been depressed?	No = 0; Yes = 1
Social Support Affective Partner Support	
Do you feel you receive adequate emotional support from your partner?	Yes = 0; No = 1
Do you feel you can confide in your partner?	Yes = 0; No = 1
Partner Instrumental* Support	
Do you feel you can rely on your partner?	Yes = 0; No = 1
Do you feel you receive adequate instrumental support* from your partner?	Yes = 0; No = 1
Family Affective Support	
Do you feel you receive adequate emotional support from your family?	Yes = 0; No = 1
Do you feel you can confide in your family?	Yes = 0; No = 1
Family Instrumental* Support	
Do you feel you can rely on your family?	Yes = 0; No = 1
Do you feel you receive adequate instrumental support from your family?	Yes = 0; No = 1
Friends Affective Support	
Do you feel you receive adequate emotional support from your friends?	Yes = 0; No = 1
Do you feel you can confide in your friends?	Yes = 0; No = 1
Friends Instrumental* Support	
Do you feel you can rely on your friends?	Yes = 0; No = 1
Do you feel you receive adequate instrumental support from your friends?	Yes = 0; No = 1

Table 5.5 Postpartum Depression Screening Scale: Selected Items by Dimension (continued)	
Marital/partner satisfaction	
Are you satisfied with your marriage or living arrangement?	Yes = 0; No = 1
Are you currently experiencing any marital/relationship problems?	No = 0; Yes = 1
Are things going well between you and your partner?	Yes = 0; No = 1
Life stress	
Are you currently experiencing any stressful events in your life such as:	
Financial problems?	No = 0; Yes = 1
Marital problems?	No = 0; Yes = 1
Death in family?	No = 0; Yes = 1
Unemployment?	No = 0; Yes = 1
Serious illness in family?	No = 0; Yes = 1
Moving?	No = 0; Yes = 1
Job change?	No = 0; Yes = 1
POSTPARTUM VERSION	
Child Care Stress	
Is the infant experiencing any health problems?	No = 0; Yes = 1
Are you having problems feeding the baby?	No = 0; Yes = 1
Are you having problems with the baby sleeping?	No = 0; Yes = 1
Infant Temperament	
Would you consider the baby irritable?	No = 0; Yes = 1
Does the baby cry a lot?	No = 0; Yes = 1
Is your baby difficult to console or soothe?	No = 0; Yes = 1
Maternity Blues	
Did you experience a period of tearfulness the first week after delivery?	No = 0; Yes = 1

*Instrumental support means help other than emotional support such as feeding the baby, grocery shopping, etc.
Reprinted with permission from Beck, C.T., Records, K., & Rice, M. (2006). Further validation of the Postpartum Depression Predictors Inventory-Revised. *Journal of Obstetric, Gynecologic, and Neonatal Nursing*, 35, 735-745.

Beck et al. (2006) developed an item coding and scoring system for the PDPI-Revised, along with a recommended cutoff point. When a woman scores above the recommended cutoff score of 10.5 on the Prenatal Version, she should be followed closely after delivery to assess whether she is showing any signs of postpartum depression. Once clinicians have utilized the PDPI-Revised to identify that a woman exhibits targeted predictors, then nursing interventions can be developed to focus on her specific problems.

Implications for Nursing Practice

A dangerous feature of postpartum depression is its covert nature, which often leaves women suffering in silence, fear, and confusion. Clinicians must remember that mothers who are suffering from postpartum depression may find it difficult to confide their feelings to others due to their shame, fear, or embarrassment. Mothers may be fearful that if they are diagnosed with postpartum depression, then their infants may be taken from them by child welfare authorities (Byatt, Biebel, Friedman, Debordes-Jackson, & Ziedonis. 2013). Postpartum nurses are in an ideal position to help dispel the destructive myths that idealize motherhood as total happiness and joy. Nurses can explain to women that early motherhood may include feelings of loss and grief. Further, nurses can convey that some mothers may experience losses, such as loss of self, loss of control, loss of energy, loss of relationships, and loss of social roles. The critical message to impart is that if these feelings—of loss and other symptoms of postpartum depression—start to interfere with a mother's functioning, that she should not be afraid to seek help.

Since mothers most likely will not experience postpartum depression before their discharge from the hospital, postpar-

tum nurses should prepare mothers for self-monitoring of potential symptoms. Before discharge, mothers and their family members, such as a partner or a sister, should be taught the signs and symptoms of postpartum depression. Sometimes, a family member may be the first person to recognize that the mother may have postpartum depression. In addition, nurses should inform new mothers about the steps to take if such symptoms arise. Nurses should stress to women that if they develop postpartum depression, this does not mean that they are weak people or that they have done anything wrong. It is not the mother's fault that she has this mood disorder, but rather it has a biochemical basis. Women need to hear that postpartum depression is a treatable mood disorder (Beck & Driscoll, 2006).

Nurses should keep abreast of resources in the community for treating postpartum depression, so they can promptly refer mothers for help. A list of support groups and local mental health professionals who specialize in postpartum mood and anxiety disorders is invaluable information that postpartum nurses can provide women before discharge. Pediatric nurses or NICU nurses may also be the first to identify mothers who may be struggling with postpartum depression. As nurses, we must be knowledgeable and caring enough to help mothers who are engaged in an unrelenting war in which the battlefield is their minds (Beck & Driscoll, 2006).

A great resource for mothers is Postpartum Support International (PSI) (www.postpartum.net), an international network that concentrates on perinatal mental health and social support. There are area PSI coordinators in all 50 U.S. states, Canada, Mexico, and in over 36 countries across the world. PSI also has a postpartum depression helpline: 1-800-944-4PPD (available in English and Spanish).

Additional nursing interventions can be gleaned from the results of a study titled, "Perceptions of Nurses' Caring by Mothers Experiencing Postpartum Depression" (Beck, 1995). This article identified seven themes that will help sensitize nurses to issues that they should consider in caring for mothers experiencing this mood disorder (Beck, 1995, p. 823):

- Theme 1. Having sufficient knowledge about postpartum depression to make a quick, correct diagnosis was viewed as an essential aspect of caring.
- Theme 2. Using astute observations and intuition lead to an awareness that something might be wrong with the mothers.
- Theme 3. Nurses provided hope that the living nightmares will end for mothers.
- Theme 4. A nurse's readily sharing valuable time was perceived as caring.
- Theme 5. Caring involved making the appropriate referrals, so that the mother was started on the right path to recovery.
- Theme 6. Caring involved the nurse making an extra effort to provide continuity of care for the mother.
- Theme 7. Understanding the nature of the mother's experience provided much-needed comfort.

Bipolar II Disorder with Peripartum Onset

The following criteria from the DSM-5 (APA, 2013) are necessary for a diagnosis of bipolar II disorder: a person must experience at least one hypomanic episode and at least one major depressive episode. To meet the criteria for a hypomanic episode, there must be a distinct period of increased mood irritability that is persistent and not normal for the individual. Also present in hypomania is an increased activity or energy level that lasts at least four consecutive days and is present for most of the day. During this period of increased activity and irritability, at least three of the following symptoms must persist to a significant degree:

- Increased self-esteem or expressions of grandiosity
- Lesser need for sleep
- Increased talkativeness
- Onset of racing thoughts
- Increased propensity to be easily distracted
- Increased activity that is goal-directed
- Increased activity in areas that have a high potential for negative consequences

A hypomanic episode is not severe enough to lead to marked impairment or to require hospitalization. Delusions or hallucinations are not present in hypomania. Because of the challenge in differentiating bipolar disorder in general from postpartum depression, bipolar II disorder is focused on in the postpartum period. Often hypomania is not diagnosed as it is mistaken for the normal joy that accompanies childbirth. The DSM-5's criteria for a major depressive episode have been listed earlier in this chapter. DSM-5 does include the specifier for bipolar disorders "with peripartum onset," which indicates that the onset of mood symptoms occurs either during pregnancy or during the first four weeks after birth.

The prevalence of bipolar II with peripartum onset is difficult to quantify. Sichel and Driscoll (1999) first coined the term "postpartum depression imposter," in reference to bipolar II. In clinical practice, Sichel and Driscoll found that women went from physician to physician seeking relief from the symptoms without responding to any of the medications prescribed. These mothers appeared to have treatment-resistant depression; when, in reality, they had undiagnosed bipolar II disorder. Women with bipolar II

disorder often report a hypomanic phase immediately after giving birth, followed by severe depression a few weeks later. Many new mothers do not see a problem when they experience a short period of goal-directed activity. However, they do view such a hypomanic episode as a negative experience and they typically do not tell anyone about it. The skill of the clinician in taking a careful life history and course of the mother's psychiatric illness is critical to the correct diagnosis of bipolar II disorder during the postpartum period.

Sharma, Khan, Corpse, and Sharma (2008) reported that 54% of 56 outpatients diagnosed with postpartum depression were later given the correct diagnosis of postpartum bipolar II disorder. Women with a history of a bipolar II disorder have an increased risk of 25-40% of developing a perinatal mood episode (DiFlorio, Forty, & Gordon-Smith, 2013; Viguera et al., 2011).

Typically, people with bipolar II disorder present to a healthcare provider during a major depressive episode. At that time, they are not likely to complain of hypomania because they do not view it as pathological. The prevalence of thoughts of self-harm and suicidal ideation during the first year after birth in women with bipolar II or major depressive disorder was examined by Pope, Xie, Sharma, and Campbell (2013). In their sample of 147 women, 17% reported self-harm thoughts and 6% reported suicidal ideation.

Treatment

Treatment for bipolar II disorder in the postpartum period includes first-line monotherapy with mood stabilizers, such as lithium or lamotrigine (Clark & Wisner, 2018; Sharma, Doobay, & Baczynski, 2017). Pharmacotherapy is the mainstay of treatment for bipolar II disorder and the benefits of prescribing medication during lactation often justify the risks, including infant restlessness or lethargy or difficulty feeding. Maternal and infant serum concentrations should be monitored for toxicity. Because women with bipolar II disorders suffer from psychosocial consequences of their psychiatric illness (Beck & Driscoll, 2006), other forms of psychotherapy are important components of the treatment plan.

Postpartum Psychosis

According to the DSM-5, brief psychotic disorder with peripartum onset is the official diagnosis for postpartum psychosis. The DSM-5 specifier for postpartum onset states that the onset of the condition takes place during pregnancy or within the four weeks postpartum. Diagnostic criteria include the presence of at least one or more of the following symptoms: delusions, hallucinations, disorganized speech, and grossly disorganized or catatonic behavior. The DSM-5 further specifies that the length of the psychotic episode is at least one day, but no more than one month, with the person returning to full premorbid functioning.

The prevalence of postpartum psychosis is estimated to be 1-2 cases per 1,000 childbirths (Kendell, Chalmers, & Platz, 1987; Munk-Olsen, Laursen, Pedersen, Mars, & Mortensen, 2006). Postpartum psychosis is a psychiatric emergency and considered one of the severest forms of mental illness. The onset is rapid and occurs during the immediate postpartum period, most often within the first two weeks after birth, but postpartum psychosis can start within three days after birth (Blackmore et al., 2013; Heron, McGuinness, Blackmore, Craddock, & Jones, 2008). It requires immediate medical attention and necessitates acute inpatient psychiatric treatment. Maternal suicide and infanticide are predominant concerns. Psychotic women can have command hallucinations to kill their baby or delusions that the baby is possessed by the devil. These mothers require careful monitoring during the postpartum period. Hamilton, Harberger, and Parry (1992, p. 35) warned that "the disorder is remarkable for its mercurial changeability, and [that] lucid intervals may give a false impression of recovery."

Women with preexisting bipolar disorder are at highest risk for developing postpartum psychosis. Since postpartum psychosis can have a rapid onset, as early as three days after birth, postpartum nurses may be the first clinicians to identify these symptoms in mothers before their discharge. If nurses suspect postpartum depression, they should also pay attention to the following indicators of postpartum psychosis: extreme agitation, confusion or exhilaration; inability to sleep or eat; difficulty maintaining a coherent conversation; hallucinations, delusions, or rapid mood swings.

An example from one of Beck's (1992) studies described the onset of one mother's psychosis: Within one week after the birth of her first child, she started acting very strange. She couldn't sleep and thought her husband was unfaithful to her. She did a lot of strange things that had religious connotations and thought God had come into her body. She believed her infant son was Jesus and that she interacted with her husband through the radio. When a certain song played on the radio, she thought he would come into the room. One evening, she filled the bathtub with scalding hot water and intended to get into the tub. She believed her husband would come in any minute and save her from burning herself. Fortunately, her husband walked into the bathroom in time to prevent her from stepping into the scalding hot water. When her husband realized the seriousness of her condition, he immediately took her to the emergency department, where she began to receive appropriate treatment (Beck, 1992).

Bergink, Rasgon, and Wisner (2016) provided an example of a patient with first onset postpartum psychosis:

> The day after the delivery, I feel very tired, but I look forward to the postpartum period. At day five, I sit behind my computer; in the adjacent room, my husband bottle-feeds our son. Our oldest son is watching TV. Without any warning sign, suddenly my thoughts are unstoppable and fly around. My brain is a centrifuge and is connected to the nearest electric outlet. My right hand makes circling movements, which I cannot control. What happened? Did I have a stroke? I get up and test myself – clearly, I can move and talk, but the environment feels strange. Something I have never felt before, an almighty feeling. I feel connected with all people in the world via invisible wires. Something terrible is going on, but I cannot figure out what this is. I am pacing up and down, not knowing what to do. Everything feels strange, and yet apparently nothing changed. I tell my husband, 'I will find you another wife.' He is shocked. I see panic in his eyes. I say to him, 'I became God' (Bergink et al., p. 1180).

Treatment

When a woman is diagnosed with postpartum psychosis, immediate treatment is necessary. One of the largest studies (N=68) of postpartum psychosis treatment demonstrated the effectiveness of a stepwise sequence of short-term benzodiazepines, antipsychotics, and lithium. This treatment resulted in remission in 98.4% of the sample (Bergink et al., 2015). Electroconvulsive therapy (ECT) is also used to treat both postpartum psychosis and postpartum depression when other treatments are not successful (Rundgren et al., 2018).

Obsessive-Compulsive Disorder in the Postpartum Period

The DSM-5 defines obsessions as "recurrent and persistent thoughts, urges, or images that are experienced, at some time during the disturbance, as intrusive and unwanted, and that in most individuals cause marked anxiety or distress" (APA, p. 237). Compulsions, on the other hand, are "repetitive behaviors (e.g., hand washing, ordering of objects, re-checking) or mental acts (e.g., praying, counting, repeating words silently) that the individual feels driven to perform in response to an obsession or according to rules that must be applied rigidly" (APA, p. 237). With such compulsive acts, a person attempts to prevent or decrease anxiety or distress in order to prevent a dreaded event. The obsessions and compulsions are distressing and time-consuming for more than one hour per day.

Russell, Fawcett, and Mazmanian (2013) conducted a meta-analysis of seven studies of OCD during the postpartum period (up to 12 months after birth) using structured diagnostic interviews, in which they reported an OCD prevalence of 2.43%. Uguz, Akman, Kaya, and Cilli (2007) reported that the rate of postpartum OCD was 4% (N=302) during the first six weeks postpartum. Miller, Chu, and Gollan (2013) reported the rate of postpartum OCD to be 11% at two weeks after birth (N=461). Miller et al. reported that almost half of this sample experienced persistent OCD symptoms at six months postpartum.

Most common obsessions in new mothers with OCD are related to contaminants, such as germs on their hands that can harm the baby, and thoughts of aggression toward the baby, such as: What if I throw my baby down the stairs? or What if I drown the baby when I am giving him/her a bath? (Fang, Berman, Chen, & Zakhary, 2018). Mothers may experience obsessive thoughts of the baby dying while asleep. In response to the obsessions, mothers exhibit compulsive behaviors, such as ritualistic hand-washing and repeatedly checking to make sure the baby is breathing.

Mothers can carry an emotional burden when living with these intrusive thoughts of harming their baby. Women are ashamed to reveal their obsessions to family, friends, or health care professionals and they are afraid their baby will be taken from them (Wenzel, 2011). These intrusive thoughts of harming their baby can be accompanied by avoidance behaviors. Mothers may distance themselves from their infants in order to avoid circumstances that they believe will lead them to act on these thoughts and harm their infants.

It is important to differentiate postpartum OCD from postpartum psychosis. In both disorders, women can have intrusive thoughts of harming the baby, but there are key differences between these two mental health disorders in new mothers, as shown in Table 5.6. In postpartum OCD, these intrusive thoughts are ego-dystonic, which means that the obsessive thoughts are not considered within the mother's reality (Wenzel, 2011). The thoughts cause great distress to mothers, and they are uncomfortable talking with others about them. In postpartum psychosis, however, these intrusive thoughts of harming the baby are ego-syntonic, which means that the thoughts are consistent with the mother's reality. Mothers with postpartum psychosis do not experience distress surrounding these thoughts, and they feel comfortable discussing their thoughts with others. Because they experience delusions and hallucinations (Spinelli, 2004), there is an increased likelihood that psychotic mothers will act on such thoughts.

Table 5.6 Key Differences Between Postpartum Obsessive Compulsive Disorder (OCD) & Postpartum Psychosis

Postpartum OCD	Postpartum Psychosis
Ego-dystonic (i.e., inconsistent with the mother's reality)	Ego-syntonic (i.e., consistent with the mother's reality)
Associated with distress	Not associated with distress
Avoids newborn	Does not avoid newborn, and instead experiences impulses to act on the thoughts
Decreased likelihood that woman will act on the intrusive thoughts	Increased likelihood that woman will act on the intrusive thoughts
In touch with reality	Not in touch with reality
Absence of associated symptoms that often co-occur with psychosis	Presence of associated symptoms that often co-occur with psychosis (e.g., loose associations, labile mood, agitation)
More common (e.g., up to 91% of new mothers experience intrusive thoughts)	Less common (e.g., 1-2 women out of 1,000 experience psychotic symptoms)
Usually occurs throughout the first several months following childbirth	Usually occurs within the first few days following childbirth.

Reprinted with permission from Wenzel, 2011. *Anxiety in Childbearing Women: Diagnosis and Treatment*, Washington, DC: American Psychological Association, p.57.

Researchers are beginning to investigate the effects of postpartum OCD on the interactions of mothers with their infants. Challacombe et al. (2016) observed mother-infant interactions with two groups: 37 mothers with OCD and their 6-month-old infants and 37 mothers without OCD and their 6-month-old infants. The group of mothers with postpartum OCD was distressed by their symptoms for a mean of 9.6 hours per day. In comparison with the control group, observers rated mothers with OCD as less sensitive to their interactions with their infants.

Treatment

Cognitive behavior therapy is an efficacious psychological intervention for postpartum OCD. It includes the components of psychoeducation, cognitive restructuring, and exposure with response prevention (Fang et al., 2018).

Panic Disorder

Panic disorder is defined as "recurrent unexpected panic attacks. A panic attack is an abrupt surge of intense fear or intense discomfort that reaches a peak within minutes" (APA, 2013, p. 208). Four or more of the following symptoms must occur for the episode to be considered a panic attack (p. 208):

- Palpitations, pounding heart, or accelerated heart rate
- Sweating
- Trembling or shaking
- Sensations of shortness of breath or smothering
- Feelings of choking
- Chest pain or discomfort
- Nausea or abdominal distress
- Feeling dizzy, unsteady, light-headed, or faint
- Chills or heat sensations
- Paresthesia (numbness or tingling sensations)
- Derealization (feelings of unreality) or depersonalization (being detached from oneself)
- Fear of losing control or "going crazy"
- Fear of dying

Other DSM-5 criteria of panic disorder include continued concern about experiencing a subsequent panic attack, followed by at least one of the panic attacks for a month or more and a significant change in the person's behavior related to the panic attacks that are maladaptive. An example of maladaptive behavior is if the mother stops going to support groups or classes for fear of having a panic attack while there (Beck, 1998).

Table 5.7 Postpartum Onset of Panic Disorder Essential Themes

1. The terrifying physical and emotional components of panic paralyzed women, leaving them feeling totally out of control.
2. During panic attacks women's cognitive functioning abruptly diminished while between these attacks women experienced a more insidious decrease in their cognitive functioning.
3. During the panic attacks, women feverishly struggled to maintain their composure, leading to exhaustion.
4. Because of the terrifying nature of panic, preventing further panic attacks was paramount in lives of women.
5. As a result of recurring panic attacks, negative changes in women's lifestyles ensued, lowering their self-esteem and leaving them to bear the burden of disappointing not only themselves but also their families.
6. Mothers were haunted by the prospect that their panic could have residual effects on themselves and their families.

Beck, C. T. (1998). Postpartum onset of panic disorder. *Image: Journal of Nursing Scholarship*, 30, 131-135.

During the postpartum period, prevalence rates of diagnosed panic attacks range from 0.5% (Matthey, Barnett, Howie, & Kavanagh, 2003) to 2.9% (Rowe, Fisher, & Loh, 2008). For some women, the onset of panic attacks occurs for the first time during the postpartum period. In the literature, this occurrence is consistent with panic disorder with postpartum onset. Mothers who have never had a panic attack prior to giving birth often present at emergency departments with chest pain and heart palpitations. Their first assessment of these symptoms is that they are having a heart attack.

What is it like for women to experience panic disorder when its onset occurs after giving birth? Beck (1998) conducted a qualitative study with five mothers who had postpartum onset of panic disorder. Of these mothers, the earliest onset was 1.5 weeks after birth, and the latest onset was 6-8 weeks postpartum. Table 5.7 illustrates six themes that the participants described as being central to their lives as new mothers with postpartum panic disorder onset. Mothers shared that both during a panic attack and in between panic attacks that their cognitive functioning was diminished, as they were consumed with worry over having a subsequent panic attack. One mother could not trust her cognitive ability; so, she explained, that she started to videotape her child singing and talking because, "When he is 15, I want to listen to this voice when he was a baby so that I can hear it when I am normal. Because I am not sure that when I hear him babbling what I am hearing is normal" (Beck, 1998, p. 133).

Fearing the next panic attack, some mothers drastically curtailed their activities outside of their homes, resulting in lowering their self-esteem and their belief that they had let their families down. One woman, who did not have a panic disorder with her first child, did experience panic attacks after the birth of her second child. Once her panic attacks started, she was no longer able to bring her first son to story hour at the library, an activity that he loved. After having to leave story hour because of a panic attack, she explained:

> I can't believe I could be so disappointed in myself. I couldn't bear that my son was losing out. I don't know. I guess I really just wanted him to enjoy story hour like all the other kids, but when I got home, I just cried. I cried for hours cause I felt like I was a bad mother. I was just so disappointed in myself, but we never went back (Beck, 1998, p. 134).

Treatment

Treatment for panic disorder can require a combination of pharmacotherapeutics and psychotherapy, such as cognitive behavioral therapy. SSRIs, monoamine oxidase inhibitors and tricyclic antidepressants are efficacious in treating panic disorder (Wenzel, 2011; 2016). When a mother is breastfeeding, lactation risk classifications, such as *Hale's Medications and Mother's Milk 2019*, should be consulted for the safety of the nursing infant.

Posttraumatic Stress Disorder

No one would question the diagnosis of PTSD in men and women who have returned from war. However, it is not as well known that PTSD can result from childbirth, even when there are no maternal or newborn complications. In this section, first, the diagnostic criteria for PTSD are explained, along with the prevalence and risk factors for PTSD, as they

relate to traumatic childbirth. Next, the long-term impact of traumatic birth and its resulting PTSD are addressed.

The DSM-5 includes the following criteria for the diagnosis of PTSD:

1. The person is exposed to actual or threatened death or serious injury or sexual violence.
2. The person experiences one or more of these intrusion symptoms that are related to the traumatic event:
   - Recurrent, intrusive memories of the traumatic event in the form of distressing dreams
   - Flashbacks about the traumatic event where the person feels as if that event is recurring. Such occurrences are considered dissociative reactions.
   - Cues that resemble aspects of the traumatic event lead to intense psychological distress
   - The person experiences marked psychological reaction to these cues related to the traumatic event
3. The person persistently avoids stimuli related to the traumatic event, such as distressing thoughts or places that are reminders of the trauma.
4. The person has negative altered cognitions and mood related to the trauma, evidenced by two or more of the following:
   - Unable to remember aspects of the traumatic event
   - Persistent negative beliefs about oneself, others, or the world that are exaggerated in nature
   - Persistent distorted cognitions related to the cause or consequences of the trauma that result in the person self-blaming or blaming others
   - Persistent negative emotions, such as fear, anger, or horror
   - Significantly decreased interest or decreased participation in important activities
   - Feeling detached or estranged from others
   - Persistent inability to have positive feelings, such as happiness or love
5. Significant alterations in arousal and reactivity related to the trauma as evidenced by two or more of these symptoms:
   - Irritability and angry outbursts
   - Self-destructive actions that are reckless
   - Hypervigilant behavior
   - Exaggerated startle response
   - Difficulty concentrating
   - Disturbances in sleep

The DSM-5 requires that these three symptoms are present: intrusion, avoidance, and negative alterations in cognitions and mood; and, that they last for more than one month and cause significant distress or impairment in the person's functioning.

Yildiz, Ayers, and Phillips (2017) reported the results of a meta-analysis of 28 studies of postpartum PTSD, in which they found a mean prevalence of 4.0% in community samples and 18.5% in high-risk groups. In a 2014 meta-analysis conducted by Grekin and O'Hara on the prevalence of PTSD after birth, the researchers reported similar results, finding a mean prevalence of 3.1% in community samples and 15.7% in at-risk samples.

In one study, the longitudinal course of PTSD after birth was examined (Dikmen-Yildiz, Ayers, & Phillips, 2018). The sample consisted of 226 women who had experienced traumatic births. PTSD symptoms were measured at 4-6 weeks and six months postpartum, and four trajectories were identified. The first trajectory was called *resilience*, where 61.9% of the sample did not meet criteria for birth-related PTSD at either time point. The next trajectory was *recovery*, (18.5%), which consisted of women who experienced PTSD at 4-6 weeks after birth but had recovered by six months postpartum. The third trajectory was *delayed-PTSD* (5.8%) which were women who did not meet birth-related PTSD criteria at 4-6 weeks postpartum but they did meet the criteria at six months postpartum. In the fourth trajectory, *chronic PTSD*, were women (13.7%) who experienced chronic PTSD at both time points. Dikmen-Yildiz et al. (2018) reported that poor satisfaction with clinicians was associated with both chronic PTSD and delayed PTSD.

In Grekin and O'Hara's 2014 meta-analysis, they identified significant risk factors for postpartum PTSD. The largest risk factor found was postpartum depressive symptoms (r = .53). Other risk factors identified had medium effect sizes: perceived quality of interactions with medical staff during labor and delivery (r = -.40), pregnancy psychopathology (r = .36), and history of psychopathology (r = .30).

In Ayers, Bond, Bertullies, and Wijma's (2016) meta-analysis for risk factors of PTSD following childbirth, the researchers included 50 studies from 15 countries that measured birth-related PTSD at least one month after birth. Significant pre-birth risk factors included: depression in pregnancy (r = .51); fear of childbirth (r = .41); poor health or complications in pregnancy (r = .38); a history of PTSD (r = .39); and, counseling for pregnancy or birth (r = .32). Risk factors during birth for postpartum PTSD included: negative subjective birth experiences (r = .59); an assisted vaginal or cesarean birth (r = .48); lack of support (r = -.38); and dissociation (r = .32). In addition, Ayers and colleagues reported that postpartum PTSD was highly co-morbid with depression (r = .60). The researchers used the results of their meta-analysis of risk factors to develop a diathesis-stress model of the etiology of birth-related PTSD (Figure 5.4).

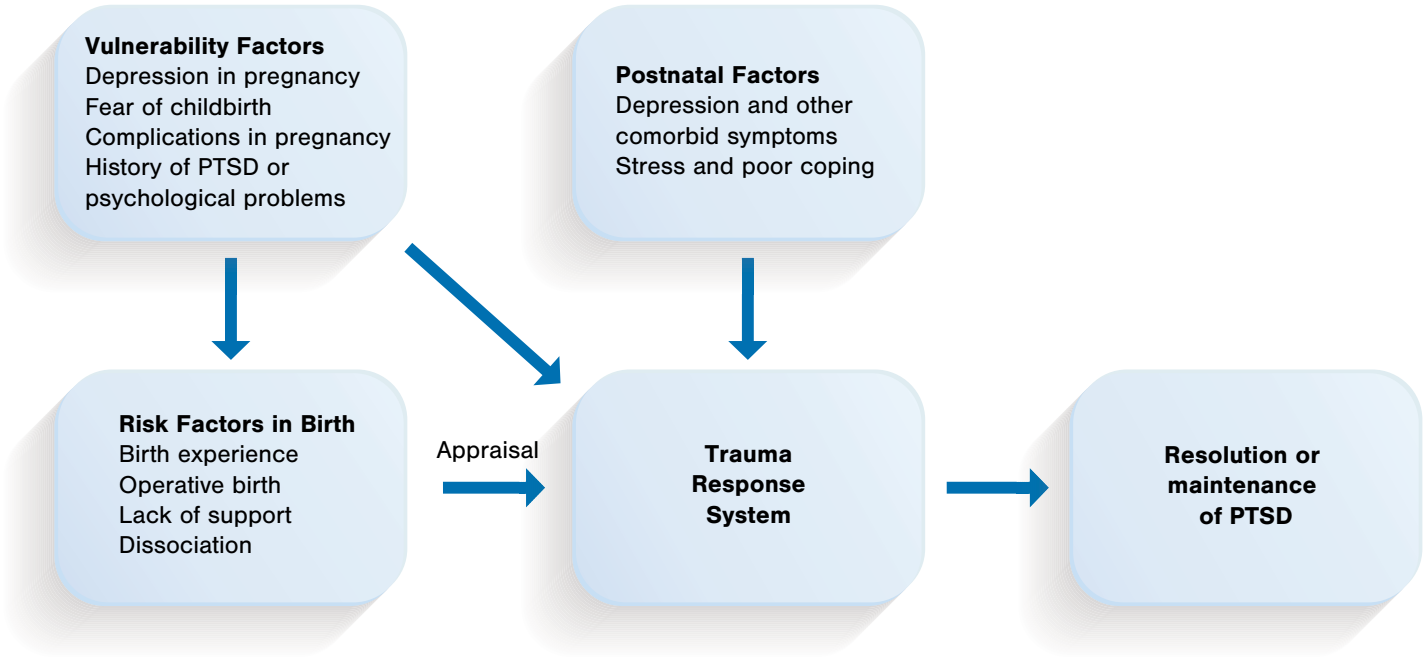


Figure 5.4 Revised Diathesis-stress Model of the Aetiology of Birth-Related Posttraumatic Stress Disorder (PTSD)
Reprinted with permission from Ayers et al. (2016). The aetiology of post-traumatic stress following childbirth: A meta-analysis and theoretical framework. *Psychological Medicine,* 46, 1121-1134.

Mothers' Voices on Traumatic Birth and its Long-Term Impact

Traumatic birth. Birth trauma is defined as "an event occurring during the labor and delivery process that involves actual or threatened serious injury or death to the mother or her infant" (Beck, 2004a, p. 28). After completing a series of qualitative studies on traumatic childbirth, Beck, Driscoll, and Watson (2013) revised this definition to also include an event occurring during the birthing process where a woman perceives she has been stripped of her dignity. Just what is it about childbirth that a woman can perceive it has been traumatic? Beck's (2004a) phenomenological study answered this question. Beck explained that, like beauty, birth trauma is in the eye of the beholder. A mother's perceived traumatic birth may be viewed quite differently in the eyes of labor and delivery clinicians who may perceive it as a routine birth. Furthermore, Beck reported that during their birthing process, women were systematically stripped of protective layers of caring.

The four themes revealed in Beck's study (2004a) gave voice to women's traumatic experiences. The first theme was, "To care for me: Was that too much to ask?" Women shared that they felt alone, not cared for, and stripped of their dignity. The following quote from one mother best summarizes this theme: "I am amazed that 3 ½ hours in the labor and delivery room could cause such utter destruction in my life. It truly was like being the victim of a violent crime or rape" (Beck, 2004a, p. 32). The second theme, "To communicate with me: Why was this neglected?", focused on how the laboring women felt invisible as clinicians spoke to one another as if the women were not there. The third theme, "To provide safe care: You betrayed my trust, and I felt powerless," brought to light the fear that some women experienced for their safety and also for their unborn baby. The final theme, "The end justifies the means: At whose expense? At what price?", highlighted how mothers felt that what they had to endure to give birth was pushed into the background as their family, friends, and labor and delivery staff focused on celebrating the birth of a healthy baby.

Theory of traumatic childbirth: The ever-widening ripple effects. Beck (2015) developed a middle range theory of the long-term consequences of traumatic childbirth from her series of qualitative studies. Beck entitled this theory, "the ever-widening ripple effect," to highlight these far-reaching negative effects, to which not much attention has been given by clinicians or researchers. In the same manner that ripples spread across the water after a stone is dropped in a pond, with each ripple getting larger and larger, a few minutes or hours in labor and delivery can be viewed as a stone which can have ripple effects in a mother's life (Figure 5.5). Each ripple represents a negative consequence for mothers: ele-

vated posttraumatic stress symptoms, full-blown PTSD, the anniversary of their birth trauma, breastfeeding difficulties, and subsequent childbirths. The next section examines each ripple and its implications for nursing practice.

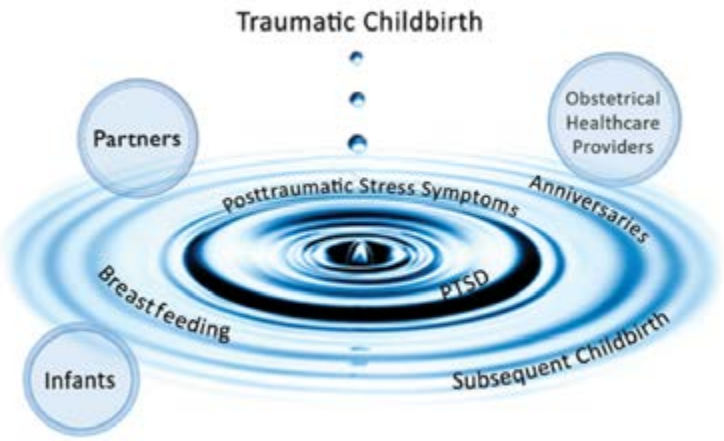


Figure 5.5 Middle Range Theory of Traumatic Childbirth: The Ever Widening Ripple Effect
Printed with permission from Beck, C. T. (2015). Middle range theory of traumatic childbirth: The ever widening ripple effect. *Global Qualitative Nursing Research.*

First, are the ripples of posttraumatic stress symptoms and PTSD due to traumatic childbirth. Women experienced the categories of symptoms of general PTSD, but for them, all of the symptoms focused on their traumatic birthing process. Mothers repeatedly talked about their "movies," the name that they gave the uncontrollable replaying of their birth trauma with flashbacks and nightmares. Implications for troubled mother-infant dyads become apparent, as this quote revealed:

> I lived in two worlds, the videotape of the birth and the 'real' world. The videotape felt more real. I lived in my own bubble, not quite connecting with anyone. I could hear and communicate, but experienced interactions with others as a spectator. The 'videotape' ran constantly for four months" (Beck, 2004b, p.219).

This mother went on to explain that this distanced interaction also applied to her infant.

A trio of the emotions, anger, anxiety, and depression encompassed the lives of mothers, which at times, escalated to rage, panic attacks, and contemplating ending their lives. Another theme with underlying implications for mother-infant bonding was "Isolation from the world of motherhood: Dreams shattered." All people with PTSD try to avoid reminders of the traumatizing event. in order to avoid flashbacks and nightmares. For mothers suffering from PTSD due to childbirth, their infants are the constant reminder of their birth trauma. As a result, some mothers put up invisible walls between themselves and their infants. Figure 5.6 illustrates these themes from Beck's qualitative study on PTSD after a traumatic birth (2004b).

Theme #		Theme
1		Going to the movies: Please don't make me go!
2		A shadow of myself: Too numb to try and change
3		Seeking to have questions answered and wanting to talk, talk, talk
4		The dangerous trio of anger, anxiety, and depression: Spiraling downward
5		Isolation from the world of motherhood: Dreams shattered

Figure 5.6 Five Essential Themes of PTSD Due to Childbirth
Reprinted with permission from Beck, C.T. (2004b). Posttraumatic stress disorder due to childbirth: The aftermath. *Nursing Research*, 53, p. 220.

Metaphors that women use to describe their experiences of PTSD due to birth trauma can provide unique insights for nurses to help them identify mothers who may be suffering from this disorder. The use of metaphors helps women explain what they are experiencing when they may not have the medical jargon to do so. Nurses can listen intently for the use of any metaphors that mothers use to describe their feelings after giving birth. Beck (2016) conducted a secondary analysis of the qualitative data from her original study of PTSD due to traumatic birth (Beck, 2004b). Her analysis revealed the following nine metaphors that women used to describe their PTSD: a mechanical robot, a ticking time bomb, an invisible wall, a video on constant replay, enveloping darkness, a dangerous ocean, a thief in the night, a bottomless abyss, and suffocating layers of trauma (Figure 5.7).

Figure 5.7 Word Cloud of PTSD Metaphors
Reprinted with permission from Beck, C. T. (2016). Posttraumatic stress disorder after birth: A metaphor analysis, *MCN: The American Journal of Maternal Child Nursing*, 41, 79.

Another ripple in this midrange theory focused on the anniversary of their traumatic birth that women struggled with each year (Beck, 2006). For family and friends, the anniversary was a day of celebration of the child's birthday but, for mothers, the day served to torment them. Four themes emerged from Beck's 2006 qualitative study:

Theme 1. The prologue: An agonizing time. During the weeks and months prior to the actual anniversary, mothers were plagued with distressing thoughts and emotions, such as dread, anxiety, grief, loss, fear, stress, and guilt. As the anniversary neared, the season of the year, calendars, and clocks took center stage. Clock-watching consumed the days and nights of some mothers. To illustrate this fixation on time, one mother recalled that:

> The entire two days before the anniversary I watch the clock and relive all the hell I know that a year or two or three now ago for the first 30 plus hours of labor I was hanging in there suffering but dealt with the pain virtually alone (Beck, 2006, p.384).

Theme 2. The actual day: A celebration of a birthday or the torment of an anniversary. For many mothers, the anniversary of the child's birth was particularly distressing because of the memory of the trauma associated with the birth. In order to survive the day that was expected to be a joyous celebration of their children's birthday, some women purposely arranged to hold parties on a different day or a different week. Fearing that the actual birthday would be a powerful trigger, such mothers chose dates that they hoped would not trigger traumatic memories. This mother describes how, for three years, she chose a random day to celebrate her son's birthday:

> We made a cake on a random day. I never told my son it was coming up. I bought him things and wrapped them, but he doesn't know what they are for. I kissed him and told him before I went to work, happy birthday, but only when he was asleep (Beck, 2006, p.387).

Theme 3. The epilogue: A fragile state. Simply managing to survive the anniversary day of their traumatic birth took a heavy toll on the mothers, such that they needed time to recuperate and heal their old wounds that had been freshly opened. As one woman admitted,

> As hard as I try to move away from the trauma, at birthday anniversary time, I am pulled straight back as if on a giant rubber band into the midst of it all and spend MONTHS after trying to pull myself away from it again (Beck, 2006, p.387).

Theme 4. Subsequent anniversaries: For better or worse. Women who had experienced multiple anniversaries did not describe one consistent pattern. For some mothers, each successive anniversary got slightly easier to manage. Other women were not as fortunate, for they did not experience any improvement with subsequent anniversaries. Describing the fifth anniversary of her birth trauma, this mother shared:

> I can't believe five years later that I feel such strong emotions and that my body responds physically. It is like the birthing trauma, and the anxiety, loss, and pain associated with it seem to reside in every cell of my being, with a memory capacity that serves to never let me forget (Beck, 2006, p.388).

Metaphor analysis of mothers' experiences of their traumatic birth anniversary revealed a rich source of insight into their yearly struggles (Beck, 2017). These metaphors characterized the anniversary of birth trauma as a great pretender, a lottery, a trigger, a clock-watcher, a giant rubber

band, a guilt trip, a sea of sadness, and bottled up anger. Nurses can listen attentively for such metaphors to help identify mothers who may be struggling with the aftermath of their birth trauma. Due to the relative invisibility of long-term consequences of a traumatic birth, clinicians may fail to rescue (support) women at the yearly anniversary of their birth trauma. Because pediatric care providers will see women each year as they bring their children in for an annual physical, they are in an ideal position to provide the support these mothers need.

The insidious effects of birth trauma also appeared in mothers' breastfeeding experiences, which was another ripple in this midrange theory (Beck & Watson, 2008). There were two different pathways that women were led down as a result of birth trauma. For some mothers, it propelled them to breastfeed; while for more women, it impeded breastfeeding, as illustrated in Figure 5.8. Some mothers shared that because they perceived they had failed at giving birth, that breastfeeding their infants was the only way that they could prove they could do something right when it came to motherhood. Mothers also admitted their feeling that the traumatic nature of their child's birth was a mortal sin for which they had to atone. What better way to atone then to breastfeed? Other factors, however, impeded their attempts at breastfeeding. Such factors included, feeling detached from their infants, and experiencing intruding flashbacks when they tried to breastfeed. Furthermore, some mothers resolved not to have any part of their body violated again after birth trauma, a factor that contributed to their early cessation of breastfeeding. They needed to protect their breasts from being handled by clinicians. On the postpartum unit, it is critical that nurses ask the mother's permission to touch her breasts when, for example, helping the baby latch on to the breast. Sometimes, nurses can put their hands over the mothers' hands to guide the initiation of breastfeeding. Nurses must be cognizant that they do not know a woman's history regarding trauma before this birth, so they must lead with respect and clear boundaries. Each nursing, while the mother is on the postpartum unit, presents a prime opportunity to facilitate maternal-infant bonding. When observing a mother breastfeeding, nurses should be attentive to signs that the mother may be struggling with the aftermath of a traumatic birth; she may appear withdrawn, dazed, or detached from her infant. If a woman is struggling to breastfeed, nurses should let her know that it is her right to choose whether to breastfeed or not, without any guilt or judgment. If a mother decides not to breastfeed or decides to discontinue breastfeeding, nurses should support her decision and not increase the burden of failure that a mother may feel.

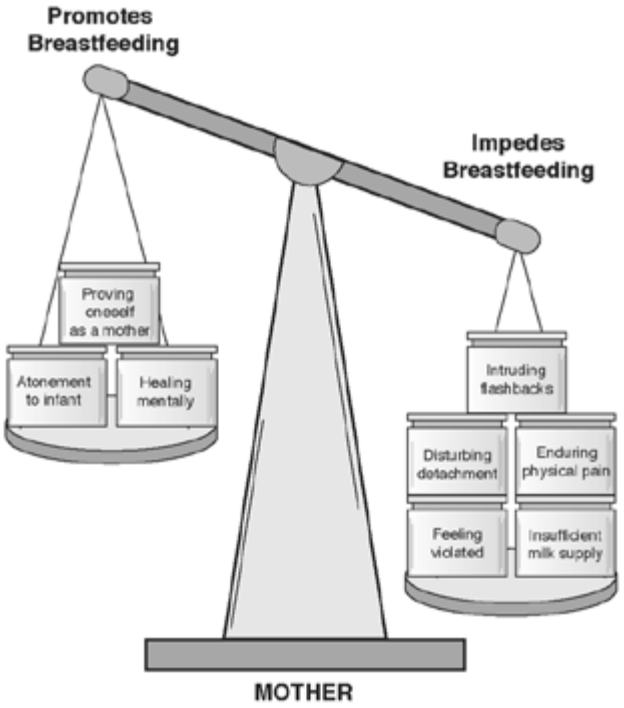


Figure 5.8 Breastfeeding Scale
Reprinted with permission from Beck, C. T., & Watson, S. (2008). Impact of birth trauma on breastfeeding: A tale of two pathways. *Nursing Research*, 57, p.232.

In this midrange theory, subsequent childbirth after a birth trauma became yet another expanding ripple. For fear of having to endure another traumatic birth, some women chose not to have more children. Other women went on to have another child, either planned or by accident. Pregnancy was filled with turbulent waves of panic as women waited for what they feared the most – another labor and delivery. Beck and Watson (2010) identified themes that described women's experiences of another birth following a previous traumatic one. Their first theme was entitled, *riding the turbulent wave of panic during pregnancy*. During the nine months of pregnancy, women shared that it was full of distressing emotions, such as fear, panic, dread, terror, and denial. This woman shared the exact moment she knew she was pregnant again with an unplanned child:

> I was on my lunch break at work, sitting under a large oak tree, watching cars go by my office, talking with my husband. I suddenly knew—I am pregnant again! I remember the exact angle of the sun, the shading of the objects around me. I remember looking into the sun, at that tree, at the windows to the office thinking, 'No! God, Please no!' (Beck & Watson, 2010, p. 245).

The second theme in subsequent childbirth focused on the different strategies women used to reclaim their bodies

and complete their journey to motherhood. Some of the strategies included: hiring a doula for the birth, practicing hypnobirthing, keeping a journal, and nurturing themselves through yoga and exercise. The third theme highlighted the need for women to bring reverence to the birthing process for the purpose of self-empowerment. As this woman explained, "I need to bring a reverence to the process so I won't feel like a piece of meat lost in the system" (Beck & Watson, 2010, p.246). What did bring reverence to this subsequent birth was an absence of the actions that were so much of a part of their prior birth trauma. Women shared that this time, "I was treated with respect, my wishes, and those of my husband were listened to. I wasn't made to feel like a piece of meat this time but instead like a woman experiencing one of nature's most wonderful events." (p.246). Women were careful, however, to make the point that even though this birth had been a healing one and different from their previous traumatic birth, that they still mourned the losses from their previous birth. They emphasized that no healing could erase the past. One mother recalled that:

> All the positive, empowering births in the world won't ever change what happened with my first baby and me. Our relationship is forever built around his birth experience. The second birth was so wonderful I would go through it all again, but it can never change the past (Beck & Watson, 2010, p.247).

Implications for nursing practice. Subsequent childbirths following a traumatic birth provide nurses with a golden opportunity to help traumatized women reclaim their bodies and complete their journey to motherhood. First, however, nurses must identify those mothers who have had prior birth trauma. If, for instance, a multipara comes to the labor and delivery unit for a stress test, nurses can engage her in a discussion about her experiences with her prior births. Giving traumatized mothers permission and encouragement to share their birth trauma helps them to deal with unresolved trauma issues. Nurses can share some of the strategies that women in Beck and Watson's study (2010) used to help them through the nine months of waiting for the birthing process to begin. When a woman goes on to have another child following birth trauma, this birth can either help heal or serve to re-traumatize the mother. Nurses have a valuable role in determining which direction the mother's subsequent birth will lead her.

In an effort to prevent these long-term ripples from a traumatic birth, postpartum nurses should explore their perceived traumatic birth with mothers *before* they are discharged from the hospital. Be vigilant in observing women during the postpartum period for any early trauma symptoms, such as a dazed look or withdrawal. Nurses may also identify women at risk for developing PTSD who may require follow-up after discharge. Nurses should recall Beck's assertion that birth trauma is in the eye of the beholder (2004a). If a mother perceives that her birth has been traumatic, then their perception is all that matters. Mothers should know that their perceptions are respected and supported by their nurses. Further, nurses should remember that not only can a traumatic birth negatively impact mothers, but it can also have a damaging impact on the developing mother-infant relationship. It is also helpful to sharing resources with mothers, such as the website of Trauma and Birth Stress (TABS), a charitable trust located in New Zealand that provides information to mothers and their families regarding birth trauma and postpartum PTSD (www.tabs.org.nz).

Effect of PTSD due to childbirth on mother-infant interaction and the relationships of couples. Researchers are currently studying the ways that PTSD due to birth trauma may impact the mother-infant relationship, infant behavior, and cognitive development. In 2018, Cook, Ayers, and Horsch conducted a systematic review of 11 studies that examined mother-infant relationship and interaction and four studies on cognitive development. Findings were mixed and inconclusive. Regarding infant cognitive development, Parfitt, Ayers, Pike, Jessop, and Ford (2014) and Parfitt, Pike, and Ayers (2014) reported a moderate association between postpartum PTSD and poor cognitive development in children at 17 months postpartum. However, Feeley et al. (2011), did not find a significant relationship between postpartum PTSD symptom scores and infant cognitive development. The evidence on the relationship between postpartum PTSD and mother-infant bonding was also inconsistent. Davies, Slade, Wright, and Stewart (2008) found that mothers who met diagnostic criteria for PTSD at six weeks after birth reported that their infants were significantly less warm toward them and had a more difficult temperament. By contrast, Ayers, Wright, and Wells (2007) did not find a significant relationship between postpartum PTSD and mother-infant bonding. In their longitudinal study of 1472 women, Garthus-Niegel, Ayers, Martini, von Soest, and Eberhard-Gran (2017) reported that PTSD due to birth trauma at eight weeks postpartum was significantly related to poor social-emotional development at two years, especially in boys and children with a difficult early temperament.

A meta-synthesis of seven studies on the impact of childbirth-related PTSD on a couple's relationship was conducted (Delicate, Ayers, Easter, & McMullan, 2018). The researchers summarized the experiences of couples in the following five themes: negative emotions, lack of understanding and support, loss of intimacy, strain on relationships, and strengthened relationships. Negative emotions included anger and arguments, depression, and detachment. Lack of understanding and support encompassed decreased

communication and mismatched support. Loss of intimacy involved sexual dysfunction and decreased romance. The strain on the relationships of couples led to frustration between partners and barriers to their closeness. For a few couples, however, their relationship ultimately was strengthened as they worked together.

Posttraumatic stress and preterm birth. In a mixed research synthesis of 25 quantitative and five qualitative studies on posttraumatic stress in mothers related to giving birth prematurely, Beck and Harrison (2017) reported prevalence rates ranging from 14% to 79%. Qualitative data synthesis of mothers' narratives identified five themes: *Shocked and horrified*, *consuming guilt*, *pervasive anxiety and hyper-vigilance*, *intrusive thoughts*, and *numbing and avoiding reminders*. Beck and Woynar (2017) conducted a mixed research synthesis on posttraumatic stress in mothers while their preterm infants were in the NICU. Instead of focusing on traumatic births, the authors focused attention on mothers' experiences of posttraumatic stress during their infants' NICU stay. Beck and Woyner synthesized 25 quantitative and 12 qualitative studies. They found that in the U.S., the prevalence of elevated posttraumatic stress symptoms was 18%. Content analysis of the findings of the qualitative study revealed five themes: *stark contrast to images of joyous motherhood*; *cultural overlay; issues of ownership and control*; *support*; *and learning to be an NICU mother*. In order to identity depressive and/or PTSD symptoms, NICU nurses should remain alert to mothers who have given birth prematurely. Once identified, these women can be given appropriate referrals. Routine screening in the NICU should be incorporated into this clinical setting.

Screening. Similar to assessment tools for postpartum depression, screening instruments are available to assess posttraumatic stress symptoms in women due to birth trauma. One such scale, based on the DSM-5's diagnostic criteria for PTSD, is the Posttraumatic Diagnostic Scale (PDS-5), from Foa et al. (2016). This is a 24-item self-report measure that assesses PTSD symptom severity during the preceding month. Its items are based on the DSM-5 symptom clusters of intrusion, avoidance, arousal, and negative alterations in cognitions and mood. The PDS-5's psychometric properties were assessed using a sample of 242 veterans, college students, and urban community residents. The results demonstrated the PDS-5 had excellent internal consistency reliability (Cronbach's alpha = .95) and test-retest reliability (r = .90). It also demonstrated good convergent validity with the PTSD Symptom Scale-Interview Version for DSM-5 (PSSI-5) (r = .85). An earlier version of the PDS-5 based on the DSM-4 criteria has often been used by researchers to assess new mothers' PTSD symptoms. The PDS-5 should now be used since it is based on the revised DSM-5's criteria for PTSD.

Ayers, Wright, and Thornton (2018) recently developed the City Birth Trauma Scale to specifically measure birth-related PTSD. The scale consists of 29 items based on the DSM-5 criteria. Its psychometric properties were assessed using a sample of 950 postpartum women who were recruited online. It demonstrated excellent reliability (Cronbach's alpha = .92). This instrument requires further testing by other researchers and clinicians.

Treatment. The treatment of PTSD due to childbirth may include psychotherapy, such as CBT, psychopharmacology, and eye movement desensitization and reprocessing (EMDR). The SSRI antidepressants are considered the first-line pharmacotherapy for PTSD. EMDR is a psychotherapy treatment that facilitates the accessing and processing of traumatic memories (Shapiro, 2018). During sessions, the person focuses on emotionally disturbing memories in short sequential amounts; simultaneously, the person focuses on an external stimulus, such as bilateral eye movements, while watching a therapist's hand as it moves back and forth across the their field of vision.

To compare treatment options, Beck et al. (2013) conducted a qualitative study with ten women who described their experiences of EMDR treatments for their PTSD due to birth trauma. They asked the mothers who had undergone both CBT and EMDR to compare these two treatments. Though both treatments helped them cope with the after-effects of their traumatic births, one woman shared "I think the EMDR definitely provides much faster and longer lasting relief from the anguish, depression, and continuously retraumatizing thoughts" (pp. 185-186). Another mother explained that:

> EMDR was absolutely the reason that I was able to get through my PTSD. When I was going to the cognitive therapist, I just found myself constantly retriggered through the questioning of my trauma, talking about my trauma, and never really resolving the pieces of my trauma that would send me into panic. EMDR and my EMDR therapist caused those triggers to dissolve through the act of rewriting those bits and pieces- those 'stuck' neural pathways that always seemed to cause panic (Beck et al., 2013, p. 186).

Posttraumatic growth after birth trauma. For mothers with PTSD due to childbirth, there is some encouraging news. Some persons who have been traumatized go on to experience posttraumatic growth. Such growth is defined as the "positive psychological change experienced as a result of the struggle with highly challenging life circumstances" (Tedeschi & Calhoun, 2004, p.1). During posttraumatic growth, the individual can improve problem areas of their lives that were present before their trauma. Tedeschi and Calhoun (1996) identified five dimensions of posttraumatic growth: *appreciation of life*; *relating to others*; *personal*

strength; *new possibilities*; and *spiritual change*. An individual does not necessarily experience growth in all five dimensions. Also, not all persons who experience trauma will develop posttraumatic growth.

In Beck and Watson's (2016) phenomenological study, mothers shared personal growth in their lives, resulting from their struggles with the aftermath of their traumatic birth. Such maternal struggles are illustrated in Figure 5.9. Four themes emerged: (1) Opening up oneself to the new present; (2) Achieving a new level of relationship nakedness; (3) Forging new paths; and (4) Fortifying spiritual mindedness. In the first theme, mothers shared that achieving posttraumatic growth was a process with potentially immense personal rewards. As one woman summarized, "I was broken. Now I am unbreakable" (Beck & Watson, 2016, p.268). Another mother recalled, "At first, the very fabric of your being is shattered, destroyed. Nothing makes sense. The pieces do not go back together again. Rather, it is a gradual, new, very different kind of becoming" (p. 267).

The second theme focused on the role that posttraumatic growth played in improving women's relationships with others. Relationships with their partner's mothers, for example, tended to improve as they reached a deeper level of understanding and a new tenderness. Their relationships with friends became deeper and closer than they had been prior to the traumatic birth. For some women, posttraumatic growth also involved, a strengthening of their faith, and an improved understanding of spiritual and religious issues in their daily life. The fourth theme revealed that some mothers established new professional and personal goals. As part of their posttraumatic growth, mothers followed two main paths. One path involved enrolling in and completing college degrees, mostly in nursing. The other path led mothers to volunteer work, which they had not been involved with before, such as, becoming active in the Birth Trauma Association.

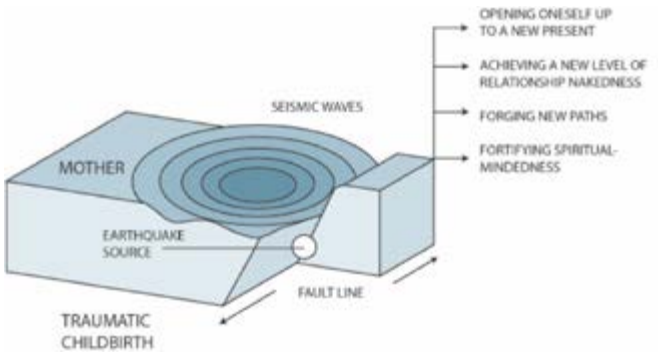


Figure 5.9 Earthquake Model of Mothers' Posttraumatic Growth after Birth Trauma

Reprinted with permission from Beck, C. T., & Watson, S. (2016). Posttraumatic growth after birth trauma: "I was broken, now I am unbreakable". *MCN: The American Journal of Maternal Child Nursing*, 41, p. 268.

Fathers and traumatic childbirth. Beck et al. (2013) conducted a qualitative study of the experiences of fathers who were present at their partners' traumatic birth. What was most prominent in fathers' narratives was their helplessness; as, for instance, one father recalled, "I am on an island watching my wife drown, and I don't know how to swim" (p. 211). One father, whose partner had a postpartum hemorrhage, recalled the following:

> Blood began gushing. Everyone began running around, and I was pushed to the side, handed my baby, and told to sit in the corner. Blood was everywhere, and they threw a bucket under my wife to help catch it all. My wife went unconscious, and it was later told to us that she lost over 2.5 liters of blood. It was like something out of a horror movie. I thought my wife was going to die (Beck et al, 2013, p. 206).

In another qualitative study of the experiences of fathers who found childbirth to be traumatic, Etheridge and Slade (2017) described findings from 11 fathers. They reported that, after witnessing the birth, fathers experienced feelings of intense fear, helplessness, and horror. Because of the speed and unexpectedness of the traumatic birth, it was explained as a "rollercoaster of emotions." These fathers recalled their attempts to "keep it together," as they felt helpless simply watching the traumatic birth happen. Fathers felt that the staff had abandoned them, and that they were not kept up-to-date on information about their partner's situation. The men explained that they needed support but they were reluctant to receive it. Often they were preoccupied with the traumatic birth, but they felt their reaction was not justified, so they used avoidance in an effort to cope.

Nurses on the postpartum unit, must remember that fathers may also be struggling due to the traumatic birth that they just witnessed. Attention should be directed at fathers and nurses should take care not to let them be forgotten.

Conclusion

There are many mood and anxiety disorders that can plague new mothers. A quick comparison of these mood and anxiety disorders is shown in Figure 5.10. The Council on Patient Safety in Women's Health Care has developed a bundle for perinatal depression and anxiety patient safety (Kendig et al., 2017), as shown in Table 5.8. The Safety Bundle provides guidance for organizations on the management of these illnesses in new mothers.

Figure 5.10 Comparison of Postpartum Mood and Anxiety Disorders

PP BLUES	PP DEPRESSION	PP PSYCHOSIS	OBSESSIVE-COMPULSIVE DISORDER
PREVALENCE: 26-84%	**PREVALENCE:** 7.1%	**PREVALENCE:** 1-2 cases per 1,000 births	**PREVALENCE:** 2.4%
RISK FACTORS: Hx of depression, relationship difficulties, premenstrual symptoms	**RISK FACTORS:** Prenatal depression & anxiety, stressful life events, low social support, poor marital relationship, intimate partner violence, preterm birth, anxiety	**RISK FACTORS:** Preexisting bipolar disorder	**RISK FACTORS:** Hx of OCD, prior hx of depression or anxiety disorders, primiparity
SYMPTOMS: Emotional lability, oversensitivity, crying	**SYMPTOMS:** Prenatal depression & anxiety, stressful life events, low social support, poor marital relationship, intimate partner violence, preterm birth, anxiety	**SYMPTOMS:** Agitated, delusions, disorganized speech, hallucinations, grossly disorganized inability to eat or sleep, catatonic behavior	**SYMPTOMS:** Recurrent & persistent thoughts, repetitive behaviors or mental acts, time consuming obsessions & consuming compulsions
NURSING IMPLICATIONS: Anticipatory guidance prior to discharge	**NURSING IMPLICATIONS:** Educate family on symptoms of PP depression, provide contact information for support groups	**NURSING IMPLICATIONS:** This is a psychiatric emergency, requiring immediate hospitalization and treatment	**NURSING IMPLICATIONS:** Risk of OCD should be assessed, refer to mental health professional

BIOPOLAR II DISORDER	PP ONSET PANIC DISORDER	PTSD DUE TO TRAUMATIC CHILDBIRTH
PREVALENCE: 26-84%	**PREVALENCE:** 7.1%	**PREVALENCE:** 4% in community samples; 18.5% in high risk groups
RISK FACTORS: Hx of depression, relationship difficulties, premenstrual symptoms	**RISK FACTORS:** Prenatal depression & anxiety, stressful life events, low social support, poor marital relationship, intimate partner violence, preterm birth, anxiety	**RISK FACTORS:** PP depression, poor quality of interactions with L&D staff, pregnancy psychopathology, hx of psychophathology, cesarean or assisted vaginal birth
SYMPTOMS: Emotional lability, oversensitivity, crying	**SYMPTOMS:** Prenatal depression & anxiety, stressful life events, low social support, poor marital relationship, intimate partner violence, preterm birth, anxiety	**SYMPTOMS:** Intrusions, avoidance, arousal, negative alterations in cogntitions & mood
NURSING IMPLICATIONS: Anticipatory guidance prior to discharge	**NURSING IMPLICATIONS:** Educate family on symptoms of PP depression, provide contact information for support groups	**NURSING IMPLICATIONS:** Prior to discharge from hospital, need to discuss with mother her perception of childbirth and refer as necessary

Table 5.8 Maternal Mental Health - Perinatal Depression and Anxiety Patient Safety Bundle: Council on Patient Safety in Women's Health Care

Readiness (Every clinical care setting)

1. Identify mental health screening tools to be made available in every clinical setting (outpatient obstetric clinics and inpatient facilities).
2. Establish a response protocol and identify screening tools and response protocol.
3. Educate clinicians and office staff on use of the identified screening tools and response protocol.
4. Identify an individual who is responsible for driving adoption of the identified screening tools and response protocol.

Recognition and Prevention (Every woman)

5. Obtain individual and family mental health history (including past and current medications) at intake, with review and updates as needed.
6. Conduct validated mental health screening during appropriately timed patient encounters, to include both during pregnancy and in the postpartum period.
7. Provide appropriately timed perinatal depression and anxiety awareness education to women and family members or other support persons.

Response (Every case)

8. Initiate a stage-based response protocol for a positive mental health screening result.
9. Activate an emergency referral protocol for women with suicidal or homicidal ideation or psychosis.
10. Provide appropriate and timely support for women, as well as family members and staff, as needed.
11. Obtain follow up from mental health care providers on women referred for treatment (this should include release of information forms)

Reporting and Systems Learning (Every clinical care setting)

12. Establish a nonjudgmental culture of safety through multidisciplinary mental health rounds.
13. Perform a multidisciplinary review of adverse mental health outcomes.
14. Establish local standards for recognition and response to measure compliance, understand individual performance, and track outcomes.

Reprinted with permission from American College of Obstetricians and Gynecologists. *Patient safety bundle: maternal mental health: perinatal depression and anxiety*. Council on Patient Safety in Women's Health Care. Washington, DC; American College of Obstetricians and Gynecologists, 2016. Available at https://safehealthcareforeverywoman.org/wp-content/uploads/2017/11/Maternal-Mental-Health-Bundle.pdf. Retrieved July 31, 2019.

Because mothers will be discharged from the hospital before most of these disorders begin, a primary responsibility of postpartum nurses is to provide anticipatory guidance to new mothers and fathers about such disorders that women and men may develop. Women should be told that if they do experience one of these disorders, that they are not weak and that they have done nothing wrong. They need to hear that these disorders are treatable; but, before that can happen, they must share their postpartum difficulties with healthcare providers, so that referrals to mental health clinicians can be made. Postpartum nurses should ideally make sure that family members also hear this anticipatory guidance, because, sometimes a family member is the first to detect that something is not right with the mother. Handouts of local support groups and perinatal mood and anxiety disorder mental health providers in the area should be given to mothers before discharge from the hospital. Nurses can also give mothers a list of helpful websites regarding postpartum mood and anxiety disorders, as shown in Table 5. 9.

Table 5.9 Website Resources for Postpartum Mood and Anxiety Disorders

Postpartum Support International	www.postpartum.net
Marcé of North America	www.marcenortham.org
International Marcé Society for Perinatal Mental Health	www.marcesociety.com
Trauma and Birth Stress	www.tabs.org.nz
Birth Trauma Association UK	www.birthtraumassociation.org.uk
Solace for Mothers: Healing After Traumatic Birth	www.solaceformothers.org
Postpartum Health Alliance	www.postpartumhealthalliance.org
Baby Blues Connection	www.babybluesconnection.org
Mother to Baby	www.mothertobaby.org
Birth Trauma Association Canada	www.birthtraumacanada.org
Prevention & Treatment of Traumatic Birth (PATTCh)	www.pattch.org

Case Study

Traumatic Childbirth Case Study

Lisa was a 34-year-old primigravida. She was admitted to labor and delivery during early labor and she was accompanied by her husband. Lisa was 38 weeks pregnant. Her labor progressed well and she was fully dilated after 11 hours of laboring. Lisa then pushed for 3 hours. The baby was in the occiput posterior position. Vacuum extraction failed, so forceps were used. The baby received Apgar scores of 8 and 9. Before Lisa could see her daughter, she began to hemorrhage. Lisa's husband was given the baby to hold and he was directed to sit in the corner. Lisa described the events that followed:

Everyone was in a panic. Someone was patting my face and trying to keep me talking. I thought I was going to die on that table. I wanted to see my baby so desperately. I kept thinking that I wouldn't ever get to see her. I had a major bleed and started shaking involuntarily all over. Even my jaw shook and I couldn't stop. I heard my doctor say he was having trouble stopping the bleeding. I was very frightened and it suddenly hit me that I might not make it. I can still recall the sick dread of real fear. I needed urgent reassurance but none was offered. I looked over at my husband sitting in the corner and he was white as a ghost.

The bleeding finally stopped and I was taken to the recovery room. My husband went with our daughter to the nursery. I started to cry because no one was around. I had never felt so alone and confused at what just happened. Finally, I was transferred to my room on the postpartum floor. I had an IV and a catheter. I was silent and felt completely numb. I did what was required like a robot and I felt my head was floating way above my body. I struggled to bring it back onto my shoulders.

The nurse brought my baby into my room so I could see her. I felt no recognition. I felt nothing. I just wanted to sleep. I had a lot of visitors while in the hospital but nobody asked how I was. Everyone was just interested in the baby. My daughter was healthy and fine and that was all that mattered. That was the message I got from my family, friends, and nurses. I did not matter. Only the baby did. My husband seemed shell shocked from witnessing my close encounter with death during my hemorrhaging. He was trying to support me as best he could but truthfully he needed help too.

I cared for my baby but I was withdrawn. Of course, I loved her but I couldn't bond with her. Everything was an effort. In retrospect what I wish for was for someone at the hospital, a nurse or midwife, to take me by the hand and get help for me as I couldn't do it on my own. I wished at that time that someone would have noticed how I was struggling and explain what had happened rather than waiting for me to say something, but I just couldn't verbalize how I was feeling.

I recorded my traumatic birth in my diary 2 days later in the middle of the night. Those days in the hospital were a blur. They were very emotional, tiring, and tense. My nightmares of my traumatic birth started right away that first night I was in the hospital. For some reason the birth experience played over and over in my head when I woke up, tried to go to sleep, and thought about in the middle of the night.

Early in the morning the day I was being discharged a nurse came in to do my vital signs and asked if I was ready to go home. I burst into tears. The nurse said not to worry I was just experiencing the baby blues all mothers go through.

Questions:

1. Which aspects of Lisa's birth did she perceive as traumatic?
   - **Hemorrhaged on the delivery table**
   - **Feared she would die**
   - **Needed urgent reassurance but none was given**
   - **Did not see her baby immediately after she gave birth**
   - **Heard the physician say that he was having trouble stopping the bleeding**
   - **Looked over and saw her husband's face "white as a ghost"**
   - **Felt all alone and confused in the recovery room**

2. What signs did Lisa exhibit that could give nurses a clue that she was struggling with the aftermath of her traumatic birth?
   - **She felt completely numb.**
   - **At times, she felt her head floating above her shoulders (dissociating).**
   - **She started having nightmares of the birth.**
   - **Traumatic birth kept replaying over and over again in her head.**
   - **She was not bonding with her baby.**
   - **She took care of her baby but everything was just mechanical.**
   - **She burst into tears the morning of her discharge from the hospital.**

3. On the postpartum unit, what occurrences added to Lisa's perception of her traumatic birth?
   - **Her family, friends, and nurses focused on the baby and not on her and what she had endured to give birth.**
   - **None of the nurses sat down with Lisa and gave her the opportunity to share her experiences of her labor and delivery.**

- **No one asked her how she was coping after her postpartum hemorrhage and whether she needed help.**
- **At discharge, the nurse minimized Lisa's experience and told her that it was just the blues.**

4. What type of support could have been given to Lisa's husband during the birth and while on the postpartum unit?
   - **While Lisa was still in the delivery room and her husband was sitting in the corner with their baby, staff could have communicated with him and kept him updated on his wife's condition.**
   - **On the postpartum unit, the nurse could have discussed his experience during the birth, asked how he was coping, and whether he needed any help.**

5. What type of anticipatory guidance and information should the nurse have provided to Lisa and her husband prior to her discharge?
   - **Provide in both verbal and in handout form, the signs and symptoms of types of postpartum mood and anxiety disorders.**
   - **Provide a list of local support groups in the area for new mothers in general, as well as for groups specifically for mothers with postpartum mood and anxiety disorders.**
   - **Let Lisa know that if she does develop one of these disorders, that it is not her fault; that she did nothing wrong; that she is not weak; and that these disorders are treatable.**
   - **Provide a list of perinatal mental health specialists in the area in the event that she requires a referral.**
   - **Give Lisa and her husband the website address of Postpartum Support International (PSI), where they can find the name and contact information of their state coordinator who they can call for help.**
   - **Let Lisa's husband know that Postpartum Support International also provides online support for fathers too.**
   - **Provide the website for Traumatic and Birth Stress (TABS), in the event that Lisa and her husband want more information about traumatic childbirth.**

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