

## Summary of Emotional Complications During Pregnancy and the Postpartum Period

|                                 | Baby Blues  | Perinatal Depression   | Perinatal Anxiety   | Posttraumatic Stress Disorder (PTSD)   | Obsessive-Compulsive Disorder   | Postpartum Psychosis   |
|---------------------------------|---|--|---|--|---|--|
| <i>What is it?</i>              | Common and temporary experience right after childbirth when a new mother may have sudden mood swings, feeling very happy, then very sad, or cry for no apparent reason.   | Depressive episode that occurs during pregnancy or within a year of giving birth.  | A range of anxiety disorders, including generalized anxiety, panic, social anxiety and PTSD, experienced during pregnancy or the postpartum period.   | Distressing anxiety symptoms experienced after traumatic events(s).  | Intrusive repetitive thoughts that are scary and do not make sense to mother/expectant mother. Rituals (e.g., counting, cleaning, hand washing). May occur with or without depression.  | Very rare and serious. Sudden onset of psychotic symptoms following childbirth (increased risk with bipolar disorder). Usually involves poor insight about illness/symptoms, making it extremely dangerous.  |
| <i>When does it start?</i>      | First week after delivery. Peaks 3-5 days after delivery and usually resolves 10-12 days postpartum.  | Most often occurs in the first 3 months postpartum. Peaks around 3-4 months after delivery. May also begin after weaning baby or when menstrual cycle resumes.   | Immediately after delivery to 6 weeks postpartum. Occasionally begins after weaning baby or when menstrual cycle resumes.   | May be present before pregnancy/birth. Can present as a result of traumatic birth. Underlying PTSD can also be worsened by traumatic birth.  | 1 week to 3 months postpartum. Occasionally begins after weaning baby or when menstrual cycle resumes. May also occur in pregnancy.   | Typically presents rapidly after birth. Onset is usually between 2 – 12 weeks after delivery. Watch carefully if sleep deprived for ≥48 hours.   |
| <i>Risk factors</i>             | Sensitivity to normal hormonal fluctuations after delivery. Life changes, lack of support and/or additional challenges (difficult pregnancy, birth, health challenges for mom or baby, twins). Prior pregnancy loss.<br><br>Dysregulated baby-crying feeding, sleep problems. Additionally, any type of trauma (medical, birth, interpersonal) and/or excessive stress (housing instability, food insecurity, financial strain, etc.) | Sensitivity to normal hormonal fluctuations after delivery. Life changes, lack of support and/or additional challenges (difficult pregnancy, birth, health challenges for mom or baby, twins). Prior pregnancy loss.<br><br>Dysregulated baby-crying feeding, sleep problems. Additionally, any type of trauma (medical, birth, interpersonal) and/or excessive stress (housing instability, food insecurity, financial strain, etc.)  | Sensitivity to normal hormonal fluctuations after delivery. Life changes, lack of support and/or additional challenges (difficult pregnancy, birth, health challenges for mom or baby, twins). Prior pregnancy loss.<br><br>Dysregulated baby-crying feeding, sleep problems. Additionally, any type of trauma (medical, birth, interpersonal) and/or excessive stress (housing instability, food insecurity, financial strain, etc.) | Sensitivity to normal hormonal fluctuations after delivery. Lack of partner support, elevated depression symptoms, more physical problems since birth, less health promoting behaviors. Prior pregnancy loss.<br><br>Dysregulated baby-crying feeding, sleep problems. Additionally, any type of trauma (medical, birth, interpersonal) and/or excessive stress (housing instability, food insecurity, financial strain, etc.) | Sensitivity to normal hormonal fluctuations after delivery. Family history of OCD, other anxiety disorders. Depressive symptoms. Prior pregnancy loss.<br><br>Dysregulated baby-crying feeding, sleep problems. Additionally, any type of trauma (medical, birth, interpersonal) and/or excessive stress (housing instability, food insecurity, financial strain, etc.) | Sensitivity to normal hormonal fluctuations after delivery. Bipolar disorder, history of psychosis, history of postpartum psychosis (80% will relapse), family history of psychotic illness, sleep deprivation, medication discontinuation for bipolar disorder (especially when done quickly). Prior pregnancy loss.<br><br>Dysregulated baby-crying feeding, sleep problems. Additionally, any type of trauma (medical, birth, interpersonal) and/or excessive stress (housing instability, food insecurity, financial strain, etc.) |
| <i>How long does it last?</i>   | A few hours to a few weeks.   | 2 weeks to a year or longer. Symptom onset may be gradual.   | From weeks to months to longer.   | From 1 month to longer.  | From weeks to months to longer.   | Until treated.   |
| <i>How often does it occur?</i> | Occurs in up to 85% of women.   | Occurs in up to 19% of women.  | Generalized anxiety occurs in 6-8% in first 6 months after delivery. Panic disorder occurs in .5-3% of women 6-10 weeks postpartum. Social anxiety occurs in 0.2-7% early postpartum.   | Occurs in 2-15% of women. Presents after childbirth in 2-9% of women.  | May occur in up to 4% of women.   | Occurs in 1-2 or 3 in 1,000 births.  |
| <i>What happens?</i>            | Women experience dysphoric mood, crying, mood lability, anxiety, sleeplessness, loss of appetite, and irritability. Postpartum depression is independent of blues, but blues is a risk factor for postpartum depression.  | Change in appetite, sleep, energy, motivation, and concentration. May experience negative thinking including guilt, hopelessness, helplessness, and worthlessness. May also experience suicidal thoughts and evolution of psychotics symptoms.   | Fear and anxiety, panic attacks, shortness of breath, rapid pulse, dizziness, chest or stomach pains, fear of detachment/doom, fear of going crazy or dying. May have intrusive thoughts of bad things happening to baby or self, and/or of harming one's baby.   | Change in cognition, mood, arousal associated with traumatic event(s) and avoidance of stimuli associated with traumatic event. Specifically, hypervigilance, irritability, intrusive trauma reminders and poor sleep are typical symptoms.  | Disturbing repetitive thoughts (which may include harming baby), adapting compulsive behavior to prevent baby from being harmed (secondary to obsessional thoughts about harming baby that scare women).  | Mood fluctuation, confusion, marked cognitive impairment. Bizarre behavior, insomnia, visual and auditory hallucinations and unusual (e.g. tactile and olfactory) hallucinations. May have moments of lucidity. <b>May include altruistic delusions about infanticide and/or homicide and/or suicide that need to be addressed immediately.</b>  |
| <i>Resources and Treatment</i>  | May resolve naturally. Resources include support groups, psychoeducation and sleep hygiene (asking/accepting other help during nighttime feedings). Address infant behavioral dysregulation—crying, sleep, feeding problems—in context of perinatal emotional complications.  | For depression, anxiety, PTSD and OCD, treatment options include individual therapy, dyadic therapy for mother and baby, and medication. Resources include support groups, psycho-education, and complementary and alternative therapies including exercise and yoga. Encourage self-care, including healthy diet and massage. Encourage engagement in social and community supports (including support groups). Encourage sleep hygiene and asking/accepting help from others during nighttime feedings. Address infant behavioral dysregulation—crying, sleep, feeding problems—in context of perinatal emotional complications.<br><br>Additional complementary and alternative therapy options for depression include bright light therapy, Omega-3 fatty acids, acupuncture and folate. |   |  |   | Requires immediate psychiatric help. Hospitalization usually necessary. Medication is usually indicated. If history of postpartum psychosis, preventative treatment is needed in subsequent pregnancies. Encourage sleep hygiene for prevention (e.g. consistent sleep/wake times, help with feedings at night).   |

<sup>1</sup>Adapted from Susan Hickman, Ph.D., Director of the Postpartum Mood Disorder Clinic, San Diego; Valerie D. Raskin, M.D., Assistant Professor of Clinical Psychiatry at the University of Chicago, IL (“Parents” September 1996)

<sup>2</sup>O'Hara MW, Wisner KL. Perinatal mental illness: Definition, description and aetiology. Best Pract Res Clin Obstet Gynaecol. 2013 Oct 7. pii: S1521-6934(13)00133-8. doi: 10.1016/j.bpobgyn.2013.09.002. [Epub ahead of print]

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