

## Summary of Perinatal Mental Health Conditions

	Baby Blues	Unipolar or Major Depression	Bipolar Disorder
<b>What is it?</b>	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. This is not considered a psychiatric illness.	Depressive episode that occurs during pregnancy or within a year of giving birth.	Bipolar disorder, also known as manic-depressive illness, is a brain condition that causes unusual shifts in mood, energy, activity levels, and the ability to carry out day-to-day tasks.
<b>When does it start?</b>	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. May also have started before pregnancy or begins during pregnancy, after weaning baby or when menstrual cycle resumes.	The average age-of-onset is about 25, but it can occur in the teens, or more uncommonly, in childhood. Some women can have a first onset in pregnancy or in the postpartum period.
<b>Susceptibility factors</b>	N/A	Personal history of depression or postpartum depression. Family history of postpartum depression. Fetal/newborn loss. Lack of personal/ community resources. Substance use/addiction. Complications of pregnancy, relationship stress, labor/delivery, or infant's health. Unplanned pregnancy. Domestic violence or abusive relationship. Adverse Childhood Experiences (ACEs).	No single cause. Likely that many factors contribute to the illness or increase risk (e.g., brain structure and functioning, genetics and family history).
<b>How long does it last?</b>	A few hours to two weeks.	2 weeks to a year or longer. Symptom onset may be gradual.	Lifelong, can be well-managed
<b>How often does it occur?</b>	Occurs in up to 85% of women.	One in seven women.	The condition affects men and women equally, with about 2.6% of the U.S. population diagnosed with bipolar disorder and nearly 83% of cases classified as severe.
<b>What happens?</b>	Dysphoric mood, crying, mood lability, anxiety, sleeplessness, loss of appetite, and irritability. Baby 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 psychotic symptoms. Thoughts of harming baby. Low self-care.	Manic or hypomanic episodes alternate with depressive episodes.
<b>Resources and treatment</b>	Resolves on its own. Resources include support groups, psychoeducation and sleep hygiene (asking/accepting others' help during nighttime feedings). Address infant behavioral dysregulation - crying, sleep, feeding problems - in context of perinatal emotional complications.	For depression, treatment options include individual therapy, dyadic therapy for mother and baby, group therapy, and medication treatment. Encourage self-care, and engagement in social and community supports. Encourage sleep hygiene and asking/accepting help from others during nighttime feedings.	Bipolar disorder responds well to treatment with individual therapy and medication management. Encourage stability in daily routine and sleep hygiene and asking/accepting help from others during nighttime feedings. Emphasize consistency with medication regime, as early hypomanic episodes can be associated with medication non-compliance and overall decompensation.

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Perinatal Anxiety Disorders		Schizoaffective and Schizophrenia	Postpartum Psychosis
<b>What is it?</b>	A range of anxiety disorders, including generalized anxiety, panic, and social anxiety, experienced during pregnancy or the postpartum period.	Schizoaffective disorder is a chronic mental health condition characterized primarily by symptoms of schizophrenia, such as hallucinations or delusions, and symptoms of a mood disorder, such as mania and depression. Schizophrenia is a psychotic illness without mood episodes.	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. Psychotic symptoms include auditory hallucinations, delusions, paranoia, disorganization, and rarely visual hallucinations. May put baby at risk.
<b>When does it start?</b>	Immediately after delivery to 6 weeks postpartum. May also begin during pregnancy, after weaning baby or when menstrual cycle resumes. May have been untreated before.	Symptoms of schizoaffective disorder and schizophrenia usually start between ages 16 and 30.	Onset is usually between 24 hours to 3 weeks after delivery. Watch carefully if sleep deprived for 248 hours.
<b>Risk factors</b>	Personal history of anxiety. Family history of anxiety. Life changes, lack of support and/or additional challenges (e.g., difficult pregnancy, birth, health challenges for mom or baby). Prior pregnancy loss. Adverse childhood experiences (ACEs).	The exact causes of schizoaffective disorder and schizophrenia are not known. A combination of factors may contribute to development of either condition (e.g., genetics, variations in brain chemistry and structure, and environment).	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.
<b>How long does it last?</b>	From weeks to months to longer.	Lifelong, can be well-managed	Until treated.
<b>How often does it occur?</b>	Generalized anxiety occurs in 6-8% in first 6 months after delivery. Panic disorder occurs in 0.5-3% of women 6-10 weeks postpartum. Social anxiety occurs in 0.2 to 7% of early postpartum women.	1% of the population is diagnosed with schizophrenia. One in every 200 people (0.5%) develops schizoaffective disorder.	Occurs in 1-3 in 1,000 births.
<b>What happens?</b>	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. Fear of going out. Checking behaviors. Bodily tension. Sleep disturbance.	Schizoaffective disorder: hallucinations, delusions, disorganized thinking, depressive and/or manic episodes. Schizophrenia: hallucinations, delusions, thought disorder, disorganized thinking, restricted affect, and cognitive symptoms (e.g., poor executive functioning skills, trouble focusing, "working memory" problems).	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. May include altruistic delusions about infanticide and/or homicide and/or suicide that need to be addressed immediately.
<b>Resources and treatment</b>	Treatment options include individual therapy, dyadic therapy for mother and baby, and medication treatment. Encourage self-care, exercise, and nutritious eating. Behavioral exercises can be taught to decrease nervous system dysregulation. Encourage engagement in social and community supports (including support groups). Address infant behavioral dysregulation as needed.	These conditions can be well managed with a careful regimen of medication and support. Medication should be continued during pregnancy and closely monitored by a psychiatric provider in combination with outpatient therapy or support groups. When well-managed, women with these conditions can absolutely be skillful and caring parents.	<b>Requires immediate psychiatric help. Hospitalization usually necessary.</b> Medication is 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). When well-managed, women with these conditions can absolutely be skillful and caring parents.

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	Borderline Personality Disorder	Posttraumatic Disorder (PTSD)	Obsessive-Compulsive Disorder (OCD)
<b>What is it?</b>	Borderline personality disorder is a condition marked by an ongoing pattern of varying moods, self-image, and behavior. Women often display impulsive actions and problems in relationships. People with borderline personality disorder may experience intense fluctuating feelings. <b>This is not a mood disorder, yet women are often misdiagnosed with bipolar disorder.</b> Borderline personality disorder is a pervasive, developmental condition that is not specific to peripartum period.	Distressing anxiety symptoms experienced after traumatic event(s). Symptoms generally cluster around intrusion, avoidance, hyperarousal, and negative world view.	Intrusive repetitive thoughts that are scary and do not make sense to mother/expectant mother. May include rituals (e.g., counting, cleaning, hand washing). May occur with or without depression.
<b>When does it start?</b>	Begins early and develops through life, though symptoms typically manifest in late adolescence or young adulthood. However, many women go through their entire lives without an accurate diagnosis. The cause of borderline personality disorder is not clear. Research suggests that genetics, brain structure and function, and environmental, cultural, and social factors play a role, or may increase the risk for it. Adverse childhood experiences (ACEs) are also associated with borderline personality disorder.	Onset may be related to labor and delivery process, traumatic delivery, or poor OB outcome. 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.
<b>Risk factors</b>	Depression or trauma/stress during pregnancy, obstetrical emergency, subjective distress during labor and birth, fetal or newborn loss, and infant complication. Prior trauma or sexual abuse. Lack of partner support. History of ACEs.	Personal history of OCD. Family history of OCD. Comorbid depression. Panic or generalized anxiety disorder. Premenstrual dysphoric disorder. Prior pregnancy loss. Preterm delivery. Cesarean delivery. Postpartum worsening.	
<b>How long does it last?</b>	Until treated.	1 month or longer.	From weeks to months to longer.
<b>How often does it occur?</b>	Occurs in 6.2% of women.	Occurs in 2-15% of women. Occurs after childbirth in 2-9% of women.	Occurs in up to 4% of women.
<b>What happens?</b>	May experience mood swings and display uncertainty about how they see themselves and their role in the world. Tend to view things in extremes, such as all good or all bad. Their opinions of other people can also change quickly, leading to intense and unstable relationships. Rejection sensitivity, anger, paranoia, self-harm, and impulsivity may be seen.	Change in cognition, mood, arousal associated with traumatic event(s) and avoidance of stimuli associated with traumatic event. Constantly feeling keyed up.	Disturbing repetitive and invasive thoughts (which may include harming baby), compulsive behavior (such as checking) in response to intrusive thoughts, or in an attempt to make thoughts go away.
<b>Resources and treatment</b>	The gold standard treatment is Dialectical Behavior Therapy (DBT). DBT uses individual, group, and phone therapy to teach mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness skills to help manage symptoms. Medication can also be helpful in addressing other untreated mental health conditions. A typical course of DBT lasts one year. Treatment is accessible through many community mental health outpatient settings.	Treatment options include individual therapy and group therapy. Encourage self-care, exercise, and healthy eating. Monitor avoidance patterns and emphasize engagement in social and community supports (including support groups). Follow up traumatic birth experiences with women. Can refer to Council on Patient Safety in Women's Healthcare "Support after Severe Maternal Event" safety bundle: <a href="https://safehealthcareforeverywoman.org/council/patient-safety-tools/support-after-a-severe-maternal-event-patient-safety-bundle-aim/">https://safehealthcareforeverywoman.org/council/patient-safety-tools/support-after-a-severe-maternal-event-patient-safety-bundle-aim/</a>	OCD can be successfully treated with a combination of behavior therapy and medication. Encourage consistency with daily routines that include self-care and exercise and nutritious diet. Encourage engagement in social and community supports (including support groups). Encourage sleep hygiene and asking/accepting help from others during nighttime feedings.

Adapted from Susan Hickman, Ph.D., Director of the Postpartum Mood Disorder Clinic, San Diego; Valerie D. Naikin, M.D., Assistant Professor of Clinical Psychiatry at the University of Chicago, IL ("Parents" September 1996) and O'Hara MW, Wisner RL. Perinatal mental illness: Definition, description and aetiology. Best Pract Res Clin Obstet Gynaecol. 2013 Oct 7; pii: S1521-6934(13)00333-8. doi: 10.1016/j.bpobgyn.2013.09.002.