PERINATAL MENTAL HEALTH CONDITIONS SUMMARY CHART

Baby Blues

What is it?	Common and temporary experience right after childbirth when a new mother may have sudden mood swings, feeling very happy and then very sad, or cry for no apparent reason. This is not considered a psychiatric illness but is a risk factor for postpartum depression.
When does it start?	First week after delivery. Peaks 3–5 days after delivery and usually resolves 10–12 days postpartum.
Susceptibility factors	N/A
How long does it last?	A few hours to two weeks.
How often does it occur?	Occurs in up to 85% of women.
What happens?	Dysphoric mood, crying, mood lability, anxiety, sleeplessness, loss of appetite, and irritability.
Resources and treatment	Resolves on its own. Resources include support groups, psychoeducation, and sleep hygiene (e.g., asking/accepting others' help during nighttime feedings). Address infant behavioral dysregulation – crying, sleep, feeding problems – in the context of perinatal emotional complications.

Unipolar or Major Depression

What is it?	Depressive episode that occurs during pregnancy or within 1 year of giving birth.
When does it start?	Most often occurs in the first 3 months postpartum. May also have started before pregnancy or during pregnancy, after weaning baby, or when menstrual cycle resumes.
Susceptibility factors	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 relationships. Adverse Childhood Experiences (ACEs).
How long does it last?	2 weeks to a year or longer. Symptom onset may be gradual.
How often does it occur?	1 in 7 women.
What happens?	Change in appetite, sleep, energy, motivation, and concentration. May experience negative thinking, including guilt, hopelessness, helplessness, and worthlessness. May also experience suicidal thoughts, evolution of psychotic symptoms, and/or thoughts of harming baby. Low self-care.
Resources and treatment	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 night feedings.

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Perinatal Anxiety Disorders

What is it?	A range of anxiety disorders, including generalized anxiety, panic disorder, and social anxiety disorder, experienced during pregnancy or the postpartum period.
When does it start?	Immediately after delivery to 6 weeks postpartum. May also begin during pregnancy, after weaning baby, or when menstrual cycle resumes. May have existed and been untreated before pregnancy.
Susceptibility factors	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 mother or baby). Prior pregnancy loss. Adverse Childhood Experiences (ACEs).
How long does it last?	From weeks to months or longer.
How often does it occur?	Generalized anxiety occurs in 6–8% of women in first 6 months after delivery. Panic disorder occurs in 0.5–3% of women 6–10 weeks postpartum. Social anxiety occurs in 0.2–7% of early postpartum women.
What happens?	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, and/or checking behaviors. May also have bodily tension, sleep disturbances, and/or irritability.
Resources and treatment	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.

Bipolar Disorder

What is it?	Bipolar disorder, previously 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.
When does it start?	The average age of onset is about 25 years old, but this condition can occur in the teens or, more uncommonly, in childhood. Some women can have a first onset in pregnancy or in the postpartum period.
Risk factors	No single cause. Likely that many factors contribute to the illness or increase risk (e.g., brain structure and functioning, genetics, and family history).
How long does it last?	Lifelong, can be well managed.
How often does it occur?	The condition affects all genders equally, with about 2.6% of the U.S. population diagnosed with bipolar disorder and nearly 83% of cases classified as severe.
What happens?	Manic or hypomanic episodes alternate with depressive episodes. A manic (week+) or hypomanic (few days) episode is a sustained period of elevated or irritable behavior that is out of character for the person and impairs their functioning.
Resources and treatment	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.

PERINATAL MENTAL HEALTH CONDITIONS SUMMARY CHART

Schizoaffective and Schizophrenia

What is it?	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 or depression. Schizophrenia is a psychotic illness without mood episodes.
When does it start?	Symptoms of schizoaffective disorder and schizophrenia usually start between ages 16 and 30.
Risk factors	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).
How long does it last?	Lifelong, can be well managed.
How often does it occur?	1% of the population is diagnosed with schizophrenia. One in every 200 people (0.5%) develops schizoaffective disorder.
What happens?	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).
Resources and treatment	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.

Postpartum Psychosis

What is it?	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.
When does it start?	Onset is usually between 24 hours to 3 weeks after delivery. Watch carefully if sleep deprived for ≥48 hours.
Risk factors	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), and prior pregnancy loss.
How long does it last?	Until treated.
How often does it occur?	Occurs in 1–3 of 1,000 births.
What happens?	Mood fluctuation, confusion, and marked cognitive impairment. Bizarre behavior, insomnia, visual and auditory hallucinations, and less frequently other types of hallucinations (e.g., tactile and olfactory). May have moments of lucidity. May include altruistic delusions about infanticide, homicide, and/or suicide that need to be addressed immediately.
Resources and treatment	An emergency that requires immediate psychiatric help. Hospitalization is usually necessary. 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

What is it?	Borderline personality disorder is a condition marked by an unstable sense of self with rapidly shifting moods, impulsive actions, and tumultuous relationships. People with borderline personality disorder may experience intense fluctuating feelings, especially in response to external stimuli. This is not a mood disorder, yet women are often misdiagnosed with bipolar disorder. Borderline personality disorder is a pervasive, developmental condition that is not specific to the perinatal period.
When does it start?	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.
Risk factors	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.
How long does it last?	Until treated.
How often does it occur?	Occurs in 6.2% of women.
What happens?	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.
Resources and treatment	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 comorbid mental health conditions. A typical course of DBT lasts one year. Treatment is accessible through many community mental health outpatient settings.

Posttraumatic Stress Disorder (PTSD)

What is it?	Distressing anxiety symptoms experienced after traumatic event(s). Symptoms generally cluster around intrusion, avoidance, hyperarousal, and negative worldview.
When does it start?	Onset may be related to labor and delivery process, traumatic delivery, or poor OB outcome. Underlying PTSD can also be worsened by traumatic birth.
Risk factors	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.
How long does it last?	1 month or longer.
How often does it occur?	Occurs in 2–15% of women. Occurs after childbirth in 2–9% of women.
What happens?	Change in cognition, mood, arousal associated with traumatic event(s) and avoidance of stimuli associated with traumatic event. Constantly feeling keyed up.
Resources and treatment	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 on traumatic birth experiences with women. Can refer to Council on Patient Safety in Women's Healthcare "Perinatal Mental Health Conditions" safety bundle: **https://saferbirth.org/psbs/perinatal-mental-health-conditions/**

PERINATAL MENTAL HEALTH CONDITIONS SUMMARY CHART

Obsessive-Compulsive Disorder (OCD)

What is it?	Intrusive repetitive thoughts, urges, or images 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. Perinatal examples include obsessively weighing diapers, checking if baby is breathing, taking infant's temperature, reviewing infant's feeding intake even when no concerns exist around malnourishment, and/or not allowing others to touch the baby.
When does it start?	1 week to 3 months postpartum. Occasionally begins after weaning baby or when menstrual cycle resumes. May also occur in pregnancy.
Risk factors	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.
How long does it last?	From weeks to months to longer.
How often does it occur?	Occurs in up to 4% of women.
What happens?	Disturbing repetitive and invasive thoughts, urges, or images (which may include harming baby), compulsive behaviors (such as checking behaviors) in response to intrusive thoughts, or in an attempt to make thoughts go away.
Resources and treatment	OCD can be successfully treated with behavior therapy alone, medication, or a combination of behavior therapy and medication. Encourage consistency with daily routines that include self-care, 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. Raskin, M.D., Assistant Professor of Clinical Psychiatry at the University of Chicago, IL ("Parents" September 1996) and O'Hara, M.W. & Wisner, K.L. (2014). Perinatal mental illness: Definition, description and aetiology. *Best Practice & Research Clinical Obstetrics & Gynaecology*; 28(1), 3-12. doi: 10.1016/j.bpobgyn.2013.09.0022013