SCREENING FOR POSTPARTUM DEPRESSION & PSYCHOSIS

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Recognize symptoms early • Screen systematically • Respond to positive findings

10–20%
estimated prevalence of postpartum depression

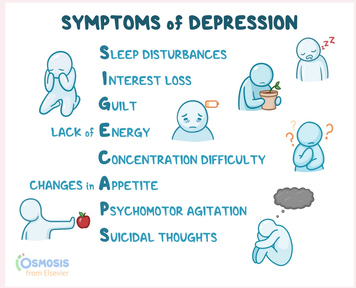
<50%
estimated proportion diagnosed

1–2/1,000
approximate prevalence of postpartum psychosis

POSTPARTUM DEPRESSION

What to recognize

- May begin within 4 weeks after birth and can occur as late as 30 weeks postpartum.
- Symptoms
  - Persistently depressed mood
  - Crying spells
  - Insomnia/Sleep disturbances
  - Fatigue
  - Anxiety
  - Poor concentration
  - Low self-esteem
  - Difficulties bonding
- Diagnosis uses the **same major depressive episode criteria as MDD**
  - ≥5 SIGECAPS symptoms
    - One of these must be depressed mood or anhedonia
  - Duration for ≥2 weeks
- In 25-50% of cases, symptoms of PPD persist for more than 7 months after delivery
  - 14.5% of postpartum women experience a new depressive episode within 3 months of parturition
    - Most episodes are mild, but 10-15% are severe (Pearlstein, 2009).
- Nearly 60% of women with postpartum depressive symptoms do not receive a clinical diagnosis (Ko JY *et al.*, 2017)
  - Patient presentation varies and symptoms can be subtle. Maintaining a high index of suspicion for PPD through the postpartum period is essential.



PPD vs. "Baby blues"

- Baby blues affect an estimated 30–80% postpartum
  - More acute onset
  - More transient
- PPD is more persistent and clinically significant; suicidal thoughts, anhedonia, or thoughts of harming the infant are red flags.
  - PPD accounts for **20% of all postpartum deaths** (Pretorian, 2026).
  - **30%** suffer **beyond a year** postpartum
  - **40%** are at risk for **recurrent** PPD in future pregnancies; 27-46 times higher after the second birth

Risk factors & context

- Xu M *et al.* found that a personal history of depression increases the odds of developing PPD by threefold
  - While bipolar disorder increases the risk of developing postpartum psychosis (Bergink *et al.*, 2025)
- Maternal risk profile impacts PPD occurrence
- Kocaayan *et al.* (2026).
- PPD was identified in 32.7% of women with high-risk cohorts demonstrated
- Many contributing factors are **social**
  - Marital satisfaction
  - Perceived social support
  - Lower quality of life (Erdoğdu & İlhan, 2026)
- Because onset can occur before delivery or later postpartum, **repeated screening** is important.
- **Nearly 70% of women with postpartum depressive symptoms also reported anxiety symptoms** (Nakić Radoš *et al.*, 2018)
  - Depression shouldn't be screened for in isolation
  - Positive screens should prompt broad mental health assessments
- Support systems matter
  - Tuszyńska-Bogucka & Bosowska (2026) showed anxiety was **positively linked** to depressive symptoms **when** self-reported **partner support was low**
    - Attachment styles in intimate relationships positively related to greater symptom severity
      - Anxious-ambivalent
      - Avoidant
  - Kobayashi *et al.* (2026) showed that **adequate support** from the new mother's family **during pregnancy** may **mitigate PPD risk, regardless of household income** level.
  - Tiske *et al.* (2026) showed **antenatal education** on childbirth-related anxiety, mode of delivery, and PPD risk was **not shown to significantly reduce PPD risk**
    - In contrast, Prajapati & Tiwari (2026) showed "new parent support group[s]" significantly reduced PPD risk, and improved bonding among mothers

Why it matters
Only a minority of affected postpartum patients are estimated to be diagnosed. A reliable screening-and-follow-up pathway can improve recognition, highlighting the demand for a defined screening protocol. ACOG recommends practices establish a defined workflow for who administers the screen, who scores it, and delineating next steps after a positive screen occurs (ACOG, 2026).
Ribeiro Feitosa *et al.* (2026), using Postpartum Bonding Questionnaires (PBQ's), showed significant association with total PBQ scores and **impaired bonding, anxiety about the infant** in the **third month postpartum**.

SCREENING TOOLS

- Why Screen?
  - Screening was associated with **lower rates of postpartum depression and increased treatment or remission,** and is effective when **connected with clinical care** (O'Connor *et al.*, 2023)
  - **A screening program is only as effective as the care pathway that follows a positive result**

- **Patient Barriers** (Hu Y *et al.*, 2023)
  - Stigma and fear of judgement
  - Misconceptions/poor recognition of depression
  - Cultural beliefs
  - Lack of social support
  - Limited treatment/provider availability
  - Lack of time
- **Physician Barriers**
  - Lack of time
  - Lack of resources
  - Concern about "opening Pandora's box"
  - **Uncertainty on how to proceed when a patient screens positive**

} **Caution: <u>Do Not Screen Without a Plan</u>**

The Edinburgh Postnatal Depression Scale — the 'Gold Standard' PPD screen

- 10 questions; about 5 minutes to complete; available in many languages.
- Includes one self-harm item—any positive response requires immediate follow-up regardless of total score.
- Draft score bands: 0–9 low risk; 10–12 possible depression; ≥13 likely MDD. **Thresholds vary by organization**.

0–9 | Low risk

10–12 | Possible depression

≥13 | Likely MDD

EPDS evidence & complementary tools

BMJ individual-participant meta-analysis (58 studies; 15,557 participants)

EPDS cutoff	Sensitivity	Specificity
≥10	85%	84%
≥11	81%	88%
≥13	66%	95%

PHQ-9

- Used instead of, or alongside, EPDS by primary care and obstetric clinicians; useful for symptom severity and longitudinal monitoring.
- Keven *et al.* (2026) strongly associated functional impairment, prior psychiatric illness, and maternal unemployment with PPD, where obstetric and neonatal variables like mode of delivery, gestational age, or birth weight did not demonstrate significant predictability

MDQ

- Not a routine PPD screener; helps identify bipolar disorder, an important risk factor for **postpartum psychosis**.

POSTPARTUM PSYCHOSIS

Diagnostic Challenges

- There is **no DSM-5-TR diagnosis called "postpartum psychosis**."
  - If the patient exhibited signs of a specific psychiatric disorder pre-pregnancy, physicians often use said diagnosis (most frequently bipolar I or MDD) with the modifiers "with psychotic features" and "with peripartum onset" (Bergink *et al.*, 2025).
  - In the absence of an underlying psychiatric disorder, "brief psychotic disorder with peripartum onset" may be used.
    - Both systems of classification have their own insufficiencies and disagreement regarding the standard duration of symptoms and how close they must be to parturition to be considered "peripartum" exists (Toor *et al.*, 2024).
- Postpartum psychosis puts bipolarism higher on the differential.
  - Patients should have a comprehensive psychiatric evaluation before starting pharmacotherapy for postpartum depression/anxiety.
    - Postpartum psychosis is **strongly associated with bipolar disorder**. Patients with BPD may see **little improvement in symptoms on antidepressant monotherapy.**
    - BPD patients experiencing postpartum psychosis often require management with antipsychotics (atypicals), benzodiazepines, and/or lithium (*ACOG*, 2024).

Warning signs

- Mania or mixed state
- Disorganized speech or behavior
- Confusion, catatonia, or severe behavioral change
- Hallucinations
- Disorganized speech

PERIPARTUM PSYCHOSIS IS A MEDICAL EMERGENCY

1. Assess safety. Determine whether the patient is a threat to themselves or others by asking about suicidal ideation, homicidal ideation, command hallucinations, and thoughts of harming the infant.
2. Ensure supervision. Do not leave the patient alone with the infant if safety is uncertain.
3. Refer for emergent psychiatric care. <u>Outpatient referrals are not recommended</u>. Patients with suspected postpartum psychosis should receive specialist psychiatric assessment within 4 hours of reporting symptoms to their medical provider *(National Institute for Health and Care Excellence*, 2025).
4. Arrange safe transportation. Local protocols may vary. If the patient is clinically stable, a responsible adult may transport her to the emergency department. However, if there are significant signs of psychosis, agitation, confusion, suicidal/homicidal thinking, or thoughts involving the infant, EMS transport to the ED is recommended.

SCREEN → ASSESS → ACT → FOLLOW UP

SCREEN
EPDS or PHQ-9 for depression.
MDQ when indicated for bipolar risk.

ASSESS
Screening ≠ Diagnosis
Confirm symptoms, severity, safety, supports, and need for diagnostic evaluation.

ACT
Any self-harm item on EPDS → **immediate review/consultation**:

Review positive screening responses
- Conduct diagnostic assessment
- Assess severity and functional impairment
- Evaluate suicide/self-harm risk
- Assess for bipolar disorder, anxiety, substance use, and medical contributors

Psychotic symptoms → urgent/emergency psychiatric evaluation.

Treatment/referral/community resources -> Coordinate OB, primary care, pediatric, and mental-health services.

Treatment based on severity:
Mild: psychotherapy + psychosocial support
Moderate/severe: psychotherapy ± pharmacotherapy
Suicidality: immediate safety intervention
Psychosis: emergency psychiatric evaluation

Treatments for PPD:
-Psychotherapy
-Support groups
-Pharmacotherapy (when indicated)

Treatments for PPP:
-Psychotherapy
-Atypical antipsychotics
-Benzodiazepines
-Lithium

FOLLOW UP
General recommendations:
Confirm connection to care
Monitor symptoms and treatment response.
Repeat EPDS or PHQ-9 periodically to assess improvement.
Escalate if symptoms worsen
Continue coordinated postpartum care

WHEN TO SCREEN

ACOG: standardized screening for depression and anxiety at the initial prenatal visit, later in pregnancy, and postpartum.

AAP: maternal depression screening at infant well visits at 1, 2, 4, and 6 months.

A positive screen should trigger a pathway for timely assessment, diagnosis, treatment, monitoring, and follow-up.

KEY TAKE-HOME MESSAGES

- Screen repeatedly—not only at the traditional postpartum visit.
- EPDS and PHQ-9 screen for depressive symptoms; they do not diagnose postpartum psychosis.
- Bipolar disorder is an important risk factor for postpartum psychosis.
- A screening program is only effective when positive findings lead to timely evaluation and care.
- Create a standardized system that identifies risk, performs appropriate clinical assessment, initiates evidence-based intervention, and ensures that patients don't fall through the cracks after referral.

REFERENCES

Poster content is based primarily on the uploaded project draft; current screening recommendations were supplemented with ACOG/AAP guidance. The draft contains additional claims and questions for further investigation; verify local protocols before clinical use.