

Postpartum Depression and Perinatal Mood Disorders in the DSM

Lisa S. Segre, Ph.D. and Wendy N. Davis, Ph.D.

Making news headlines, in May 2013 the *American Psychiatric Association (APA)* released the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)*. This revision was chaired by David J. Kupfer, M.D (Chair) and Darrel A. Regier, M.D., M.P.H. (Vice-Chair), and a task force comprised of 13 work-groups: each comprised of a chair and work group members who were key experts in psychiatric treatment, research and epidemiology. (See following url for more information on the committee: <http://www.dsm5.org/Pages/Default.aspx>)

The DSM, which has been called “the bible of diagnostic criteria” for mental health professionals and researchers, is used to determine whether a cluster of symptoms is recognized as a disorder, according to the APA. This recognition can have substantial practical consequences, for example whether or not treatment is reimbursed by insurance or in determining outcomes in court cases. As an organization devoted to the emotional well-being and mental health of pregnant and postpartum women, Postpartum Support International is keenly interested in psychiatric diagnostic developments during pregnancy and the postpartum period. The purpose of this article is to describe recent changes in the DSM-5 that pertain to pregnant and postpartum women. However, for individuals who may not be familiar with prior versions of DSM, it may be challenging to understand the significance of recent changes. The following very brief history provides this background as a framework.

Did you ever wonder why this manual is called the Diagnostic and *Statistical* Manual? While the word “diagnostic” is easily understood, the reference to “statistical” is not intuitive.

Diagnostic Classification for Census

Although *diagnoses* have been around for a very long time, the first diagnostic classification *system* was developed for the purpose of documenting the number cases of “idiocy/insanity” in the 1840 census. By the time of the 1880 census, an expanded classification scheme recognized seven psychiatric illnesses: mania, melancholia, monomania, paresis, dementia, dipsomania, and epilepsy. In 1917 the Census Bureau, still with a focus on ***counting and statistics***, developed an expanded classification scheme to gather standardized data from mental institutions with the assistance of two collaborating organizations: the *American Medico-Psychological Association* and the *National Commission on Mental Hygiene*. This classification, titled *Statistical Manual for the Use of Institutions for the Insane*, included 22 diagnoses. Shortly after this collaboration, in 1921, the *American Medico-Psychological Association* changed its name to the *Committee on Statistics* of the *American Psychiatric Association*.

Diagnostic Classification for Assessment and Treatment

The large scale involvement of U.S. psychiatrists in World War II (1939-1945) shifted the focus of these psychiatric diagnostic classifications from use in census to a more applied use: the selection, assessment, and treatment of soldiers. In 1943 Brigadier General William C. Menninger, founder of the Menninger Clinic, developed a broader classification scheme which addressed these more practical issues and also which addressed symptoms frequently presented by World War II active duty servicemen and veterans. This classification scheme --called the

Medical 203-- was eventually adopted by all armed forces and also used by many military psychiatrists in civilian hospitals and clinics upon their return to civilian practice. Around the same time of the development of the *Medical 203*, the World Health Organization (WHO) published a 6th edition of the International Classification of Diseases (ICD), which for the first time included a classification scheme for *mental* disorders. With several different classifications schemes now in use, in 1950, the *APA Committee on Nomenclature and Statistics* was charged with the task of creating a standardized classification scheme for the use in the U.S.

In 1952 the first *Diagnostic and Statistical Manual of Mental Disorders* was published and referred to as DSM-I with George Raimos, M.D. as the chairman of the *Committee on Nomenclature and Statistics*. The structure and content of this new manual was very similar to the *Medical 203*, in fact a significant portion of the text was identical. Since the first edition in 1952, the DSM has been extensively revised as indicated in the following timeline describing DSM-I through DSM-IV-TR (Figure 1).

Edition	Year	Description
I	1952	106 diagnoses Heavily influenced by psychoanalytic theory. For example phobias: “generally attributed to fears displaced to the phobic object.”
II	1968	182 diagnoses similar structure to DSM-I
III	1980	265 diagnoses Strove to be a theoretical; introduced the explicit diagnostic criteria for each disorder; introduced a multi-axial system that included specification of disorder as well as ratings of physical conditions, severity of stressors and ratings of functioning
III-R	1987	Removed the hierarchical criteria so that comorbid disorders could each be recognized
IV	1994	297 diagnoses Reorganized disorders in terms of axis Changed rating of severity of stressor to a checklist
IV-TR	2000	365 diagnoses Minor changes to descriptions of some disorders

Figure 1: DSM-I to DSM-IV-TR

Depression in DSM

As indicated in Figure 2, the diagnosis of depression has evolved with each revision. Although depression during the postpartum period is frequently referred to as “postpartum depression,” in the DSM depression during the postpartum period is not distinguished as a unique diagnostic category. Instead, depression during the postpartum period is classified as “Major Depressive Disorder, with postpartum onset”. Interestingly, this onset specifier was not introduced into the classification system until 1994 with the publication of DSM-IV.

DSM-I	<p>Psychoneurotic Disorders: 000-x06 Depressive reaction The anxiety in this reaction is allayed and hence partially relieved, by depression and self-deprecation. The reaction is precipitated by a current situation, frequently by some loss sustained by the patient, and is often associated with a feeling of guilt for past failures or deeds. The degree of the reaction in such cases is dependent upon the intensity of the patient’s ambivalent feeling toward his loss (love, possession) as well as upon the realistic circumstances of the loss.</p>
DSM-II	<p>300.4 Depressive neurosis This disorder is manifested by an excessive reaction of depression due to an internal conflict or to an identifiable event such as the loss of a love object or cherished possession. It is to be distinguished from involuntional melancholia and manic depressive illness</p>
DSM-III	<p>Affective Disorders: Major Depressive Disorder The essential feature is a dysphoric mood, unusual depression, or loss of interest or pleasure in all or almost all usual activities and pastimes. This disturbance is prominent, relatively persistent, and associated with other symptoms of depressive syndrome. These symptoms include appetite disturbance, change in weight, sleep disturbance, psychomotor agitation or retardation, decreased energy, feelings of worthlessness or guilt, difficulty concentrating or thinking, and thoughts of death or suicide or suicidal attempts. Diagnostic Criteria: Sad mood or loss of interest: prominent and relatively persistent and at least four other symptoms described above. A fifth digit code was introduced and included: in remission, with psychotic features, with melancholia, without melancholia, and unspecified.</p>
DSM-III-R	<p>Affective Disorders: Major Depressive Disorder The essential feature of MDD is either depressed mood (or possibly in children or adolescents an irritable mood) or loss of interest of pleasure in all, or almost all, activities and associated symptoms for a period of at least two weeks. The symptoms represent a change from previous functioning and are relatively persistent, that is they occur for most of the day nearly every day during at least a two week period. The associated symptoms include appetite disturbance, change in energy, sleep disturbance, psychomotor agitation or retardation, decreased energy feelings or worthless or excessive or inappropriate guilt, difficulty thinking or concentrating and recurrent thoughts of death or suicidal ideation or attempts. 5th codes: mild, moderate, severe with psychotic without psychotic features, severe with psychotic features, in partial remission, in full remission, unspecified</p>

Figure 2: Depression in DSM-I to DSM-III-R

DSM-IV Introduction of the Postpartum Onset Specifier

Major Depressive Disorder with postpartum onset was not recognized in the DSM until the publication of the DSM-IV in 1994. As in prior editions, the definition and criteria for Major Depressive Disorder also continued to evolve:

The essential feature of MDE is a period of at least 2 weeks during which there is either depressed mood or loss of interest or pleasure in nearly all activities. In children and adolescents, the mood may be irritable rather than sad. The individual must also experience at least four additional symptoms drawn from a list that includes: changes in appetite or weight, sleep and psychomotor activity, decreased energy, feelings of worthlessness or guilt, difficulty thinking, concentrating or making decisions, or recurrent thoughts of death or suicidal ideation, plans or attempts. To count toward a Major Depressive Episode symptoms must either be newly present or must have clearly worsened compared with the person's pre-episode status. The symptoms must persist for most of the day nearly every day for at least 2 consecutive weeks. The episode must be accompanied by clinically significant distress or impairment in social, occupational, or other important areas of functioning.

The diagnostic criteria for Major Depressive Disorder also included a list of specifiers to describe the most recent mood episode one of which was “with postpartum onset: defined as within four weeks of delivering a child.” It was noted that this specifier could be applied to current or most recent Major Depressive, Manic or Mixed Episode of Major Depressive Disorder, Bipolar I Disorder, Bipolar II disorder, or to Brief Psychotic Disorder. This diagnostic classification did not change in DSM-IV-TR.

Even before the publication of DSM-IV-TR in 2000, early planning for the DSM-5 revisions was in progress. In 1999 the first white papers were developed, in 1994 the *National Institute of Mental Health* held the first conferences to organize the revision, and in 2006 DSM-5 chairs and members were appointed.¹ The revised version was related in May at the annual conference of the American Psychiatric Association.

Postpartum Support International and the DSM-5:

In October 2010, at the biennial meeting of the Marcé Society and PSI annual conference held in Pittsburgh, we heard a panel presentation on the DSM5 revisions in which it was revealed that the postpartum onset specifier would not be extended, and that the committee did not find persuasive evidence to indicate that postpartum depression is distinct from other existing depressive disorders. There was a palpable reaction in the audience and during the opportunity for Q&A, lines quickly developed behind the microphones. PSI members bravely walked to the microphone and in front of a large audience of perinatal researchers, professionals, and PSI members, made the concise argument that the conclusions of the workgroup seemed a disservice to many women. In particular, many PSI members have commented on the contributions of Katherine Stone from Postpartum Progress and Adrienne Griffen from Postpartum Support

¹ Halter, J.J., Rolin-Kenny, D. & Grund, F. (2013). DSM-5 Historical perspectives. *Journal of Psychosocial Nursing*, 51, 22-29.

Virginia. Additionally, a PSI professional member posed an incisive question, asking whether the methods of data analysis, interpretation, and conclusion were consistently applied across all of the workgroups of the DSM-5 revisions, and asserted that systemic consistency would give the greatest credibility to the whole project.

During the process of public input and testimony for DSM5 revisions during 2012, PSI was invited to the American Psychiatric Association briefing meeting held in May. PSI Representative Lorraine Caputo, LCSW, attended the meeting, and we further followed up with letters to the review committee.

In our input to the committee we wrote:

We continue to support the recommended addition of a specifier, as it is stated on the DSM 5 website, “With Postpartum Onset,” that can be applied to a current or most recent Major Depressive Episode, Manic, or Mixed Features in Major Depressive Disorder, Bipolar I Disorder, or Bipolar II Disorder, or to Brief Psychotic Disorder, and that the onset of the episode be extended to *within 6 months postpartum*.

We would also recommend, very highly, the addition of *the 6 month onset specifier to the Mixed Depression and Anxiety Disorder and Obsessive Compulsive Disorder* as well, for the following reasons: In general many postpartum women present with a mixed depression and anxiety picture so the Mixed Depression and Anxiety Disorder seems to be a recognizable diagnosis for primary care doctors and obstetricians who will see many of these women in their practices. In addition, it is important for doctors and other mental health professionals to be trained to diagnose postpartum depression, anxiety, OCD and psychosis to insure the proper treatment and education of their patients and their families. Many families do not understand the nuances of these conditions in the Perinatal time period and depend on solid information and diagnosis to help them know how to support their loved ones. In addition, many women who develop OCD in the postpartum period often have intrusive thoughts about hurting themselves and/or their infants. General practitioners and obstetricians will utilize the DSM 5 to help them recognize this OCD in the context of postpartum depression and anxiety.

As you know Postpartum Support International is a worldwide organization made up of over 600 professional and non-professional members, both individual and institutional. Our membership vocalized their concerns about the DSM 5 and the importance of recognizing the 6 month onset of this condition in affective disorders at the International Marce/PSI conference in Pittsburgh. We are grateful that our voices were heard in this matter. We hope you will consider our additional recommendations in this letter.

DSM-5 and Depression in Postpartum Period

When the new DSM-5 was published, there was a notable revision to the Diagnosis of Major Depressive Disorder, which was the removal of the bereavement exclusion. In prior DSM classifications, individuals with significant depressive symptoms that occurred within two months of the loss of a loved one were excluded. DSM-5 recognizes that while symptoms are understandable, the clinician should carefully consider the possibility of a Major Depressive Disorder in addition to normal sadness resulting from loss.

What about the postpartum onset specifier? In DSM-5 the diagnosis of depression during the postpartum period still utilizes the onset specifier format. However the specifier has changed it is now titled “**with peripartum onset**” which is defined as the most recent episode occurring *during pregnancy* as well as in the four weeks following delivery. This official recognition of

depression during pregnancy represents a significant step forward! It is however disappointing that the period following delivery was not extended to recognize that real suffering often occurs during the first year, as PSI and others had lobbied.

What happened? As noted by O'Hara and McCabe in a recent review of the status of postpartum depression², the DSM-5 mood disorders workgroup did consider extending the four week specifier from 4 weeks to 6 months. In this review they also aptly note that, indeed in clinical practice and research, regardless of the DSM criteria, women with a depressive disorder onset within 12 months of birth are often classified as having "Major Depressive Disorder, with postpartum onset." Yet, the workgroup decided that ultimately the available epidemiological evidence to support such an extension was not yet compelling.

Toward the Future

We are encouraged that the DSM now includes depression during pregnancy, which represents a significant revision and a step forward, especially considering the recognition of depression in postpartum women is relatively recent. It is also significant that it acknowledges the co-existing symptoms of anxiety and panic. *"Fifty percent of "postpartum" major depressive episodes actually begin prior to delivery. Thus, these episodes are referred to collectively as peripartum episodes. Women with peripartum major depressive episodes often have severe anxiety and even panic attacks."* However, in contrast, there is considerable disappointment that the time frame for postpartum depression was not extended. It is obvious that we need more published research on the time frame of symptom onset during the year after childbirth. We hope that a future revision will include the later onset of symptoms as well as the peripartum onset specifier for anxiety disorders, obsessive disorders, and hypomania, which will provide crucial diagnostic and treatment guidance.

It is important to clarify that although that the DSM has been casually referred to as "the bible" of diagnosis and assessment, PSI and other allied organizations are full of trained perinatal mental health professionals, supporters, and survivors who do understand the elements for which we advocated through the DSM revision: the broader time of onset, the importance of diagnostic and statistical criteria through specifiers for anxiety, mixed anxiety/depressive disorder, obsessive disorder, hypomania, and traumatic stress disorders. As an organization, PSI will continue to advocate for more research to clarify the range of onset and recovery, and to bring that research to light in any further DSM revisions. However, the wait for those changes does not stop any of us from acting on our more direct and immediate goals: to continue to increase public and provider awareness with reliable information and access to support, expressing the real experiences of pregnant and postpartum mothers and fathers and increasing the numbers of trained providers to offer reliable, compassionate, and informed care and treatment.

² O'Hara, M.W. & McCabe, J.E. (2013). Postpartum depression: Current status and future directions. *The Annual Review of Clinical Psychology*, 9, 379-407.