The Course of Postpartum Psychiatric Disorders in Women and Their Partners

PHYLLIS ZELKOWITZ, Ed.D., and TAMARA H. MILET, M.D.¹

This study examined the course of postpartum psychiatric disorders in a community sample of mothers and their partners to determine whether sociodemographic variables, life stress, and psychiatric history were related to persistence of mental health problems. At 6 months postpartum, 48 index couples where the wife had a psychiatric disorder at 2 months postpartum and 50 control couples with no such diagnosis underwent diagnostic interviews and completed questionnaires on psychological symptoms, life stress, and treatment history. The results indicate that at follow-up, 54% of the index mothers still had a psychiatric diagnosis, as did 60% of their partners who had had a psychiatric diagnosis at 2 months postpartum. Socioeconomic status, country of origin, and life stress were related to persistence, as were diagnosis and timing of onset of the disorder. About a third of the parents were referred for treatment. It is concluded that for many families, postpartum psychiatric disorders are not a transient phenomenon.


Postpartum psychiatric disorders pose a significant mental health problem in the community because of their prevalence and their impact on parent-infant and couple relationships (Campbell et al., 1992; Gotlib et al., 1991; Murray and Cooper, 1997; Weinberg and Tronick, 1998). Rates of postpartum depressive disorders vary with the method of assessment and the timing of the evaluation; on average, approximately 13% of childbearing women are affected (O’Hara and Swain, 1996). There is also an elevated risk for anxiety disorders during the postpartum period (Altshuler et al., 1998). The partners of women with postpartum psychiatric disorders are themselves at risk for mental health problems (Ballard and Davies, 1996; Fawcett and York, 1986; Lovestone and Kumar, 1993; Raskin et al., 1990; Soliday et al., 1999; Zelkowitz and Milet, 1996). A similar set of risk factors is associated with postpartum psychiatric disorders in both mothers and fathers: a history of mental health problems (during pregnancy or earlier), stressful life events, a lack of social support, and poor marital adjustment (Areias et al., 1996b; O’Hara and Swain, 1996; Swendsen and Mazure, 2000; Zelkowitz and Milet, 1996, 1997). Demographic variables, such as socioeconomic status (SES) and family size, have not been consistently found to be related to postpartum psychiatric disorders in women (O’Hara, 1995); however, immigrant status may place women at risk for mental health problems after childbirth (Fisch et al., 1997; Glasser et al., 1998; Zelkowitz, 1996; Zelkowitz and Milet, 1995).

There are limited data on the course of postpartum psychiatric disorders. A significant number of women, perhaps as many as one third of those with postpartum depression in the first 3 months after birth, continue to be symptomatic at 6 months postpartum (Areias et al., 1996a; Campbell and Cohn, 1997; Milgrom and McCloud, 1996). Few data are available on the course of postpartum disorders in fathers, with one study reporting that 3 of 10 fathers who were symptomatic at 6 weeks postpartum continued to have elevated levels of depressive symptoms at 6 months postpartum (Ballard et al., 1994). There is little information on factors associated with chronicity, though past psychiatric history and family history of mental illness were not found to be related to a chronic course in women (Campbell and Cohn, 1997). This literature is also limited by the fact that most studies include only primiparous women; it is important to consider the effects of parity on the course of the disorder, because responsibility for several young children is a risk factor for depression.
In the present study, we report a 6-month follow-up of a community sample of women who were evaluated for psychiatric disorders at 2 months postpartum. We also examined continuing mental health problems in their partners. A further purpose of the study was to identify factors associated with persistent mental health problems in childbearing women and their partners, including sociodemographic variables, life stress, psychiatric and treatment history.

**Methods**

**Participants**

The sample for this 6-month follow-up study includes 48 of 50 women who had participated in a study of postpartum psychological adjustment and who had been diagnosed with a psychiatric disorder at 2 months postpartum. In addition, all 50 women who had been recruited as controls participated in the 6-month follow-up. All the women were recruited through two community health centers that make routine postpartum contacts with all childbearing women in their catchment areas. The sample included English- and French-speaking women who were married or living in a stable relationship and had a singleton birth with no significant perinatal complications.

Details of the recruitment procedures can be found in Zelkowitz and Milet (1996). In brief, there was a two-stage approach for identifying women with postpartum psychiatric disorders at 2 months postpartum. Women were screened over the telephone by using the Edinburgh Postnatal Depression Scale (EPDS; Cox et al., 1987). Those agreeing to participate who scored at or above the cut point of 10, which is recommended for community screening with this measure, were then interviewed in their homes by a clinical psychologist to determine whether a diagnosis was present. Of the 119 women screened who had scores above the cut point, 61 (51%) agreed to participate. Eleven women were subsequently excluded because they had no current diagnosis upon interview. There was no difference between participants and nonparticipants in age, parity, gender of infant, or SES.

The index group consisted of women who met criteria for a current axis I disorder; cases were identified in this manner because postpartum psychiatric illness can be manifested through a variety of symptoms and syndromes, including depression, panic disorder, and obsessive-compulsive disorder (cf. Metz et al., 1988; Sichel et al., 1993). At the 2-month assessment, 20 women (42%) met criteria for major depression, and 20 (42%) met criteria for adjustment disorder with depressed mood. Eight women (17%) met criteria for anxiety disorders.

The control group was comprised of women who scored below 7 on the EPDS and had no current diagnosis on clinical interview. Partners of women in both groups also participated in the research. Control couples were matched to index couples on the basis of parity and SES. For half the couples, the current pregnancy was their first; the other couples were having second or third children.

Two index couples refused to participate in the 6-month follow-up. In addition, two other couples (one index and one control) had separated by 6 months postpartum; both mothers and the control father completed the assessment, whereas the index father did not. Thus, the final sample at 6 months postpartum consisted of 98 women and 97 men. Demographic characteristics of the sample are presented in Table 1.

**Measures**

**Edinburgh Postnatal Depression Scale (EPDS).** This is a 10-item scale specifically designed to screen for postpartum depression in community samples (Cox et al., 1987). This measure has also been used to screen for postpartum anxiety disorders (Ballard et al., 1993). The items are rated on a scale from zero to three and refer to depressed mood, anhedonia, guilt, anxiety, and suicidal ideation, as experienced in the past 7 days. The scale is internally consistent and has adequate sensitivity.
and specificity, as compared with a psychiatric diagnosis of major depression (Cox et al., 1987; Murray and Carothers, 1990). The authors recommend the use of a cut point of 9/10 to increase sensitivity for the purposes of community screening. Sensitivity in our study population was found to be 91% (Zelkowitz and Milet, 1995).

Structured Clinical Interview for DSM-III-R, Non-Patient Version (SCID-NP; Spitzer et al., 1990). This semistructured interview was used to make current as well as lifetime axis I diagnoses at 2 months postpartum. Interrater reliability in this study was established by having an observer present during 12 interviews. A kappa of .77 between the two raters on the presence or absence of specific diagnoses was obtained.

Longitudinal Interval Follow-up Evaluation (LIFE; Keller et al., 1987). This is a semistructured interview designed to track the course of diagnoses made with the SCID and of symptoms that may have arisen during the follow-up interval. This instrument has demonstrated interrater reliability for weekly changes in symptomatology, with intraclass correlations in the .90 range. For the purposes of this study, the interviewer reviewed the period from the initial assessment at 2 months postpartum until the follow-up assessment at 6 months postpartum to determine the presence of symptoms on a weekly basis. Participants who continued to meet diagnostic criteria at 6 months were considered to be persistent cases, whereas those who no longer met diagnostic criteria were classified as “in remission.”

Symptom Checklist 90 - R (SCL-90-R; Derogatis, 1983). The somatization, depression, and anxiety subscales of this self-report inventory were used to assess psychological symptoms in both spouses. This questionnaire was completed at 2 and 6 months postpartum.

The Life Stress Scale of the Parenting Stress Index (Abidin, 1990) is a list of 19 stressful life events, relating to friends and family, work and schooling, income, and health. Respondents indicate whether or not each event has occurred in the past 12 months. The total number of stressors was calculated for each respondent, and weighted according to the scoring manual for the measure.

Treatment History. Respondents were asked whether they had been referred for treatment for mental health problems during the period between the 2- and 6-month assessments and whether they had sought treatment. Those who had done so were asked to indicate the type of treatment provider they had seen.

Procedures

Both partners in all participant couples were interviewed individually by a clinical psychologist. Interviews took place in the couple’s home, at approximately 6 months postpartum. While one partner was being interviewed, the other completed the self-report measures.

Statistical Analyses

The chi-square statistic was used to compare groups on categorical variables, including remission, type of diagnosis, and sociodemographic variables, such as employment status and country of origin; logistic regression was employed for multivariate analysis of the variables associated with remission rates. Student’s t statistic was used to compare groups on continuous variables such as parental age and years of education. Repeated measures analysis of variance was employed to examine differences in psychological symptoms related to time of assessment and diagnostic group. Correlational analysis was used to determine the relationship between stressful life events and psychological symptoms.

Results

Factors Associated with Psychiatric Diagnosis in Mothers at 6 Months Postpartum

Of the 48 women in the index group, 26 (54%) continued to be symptomatic at 6 months postpartum. Sixteen (62%) women had depressive disorders, four (15%) had adjustment disorders with depressed mood, and six (23%) had anxiety disorders. Among those with major depression, two had co-morbid diagnoses of dysthymia, and five had co-morbid diagnoses of generalized anxiety disorder. One woman in the control group was diagnosed with an anxiety disorder at 6 months postpartum.

A past history of mental health problems was not related to remission, with approximately two-thirds of the women in both the remitted and symptomatic groups having reported a history of such problems when they were assessed at 2 months postpartum. Timing of the onset of the disorder that had been diagnosed at 2 months postpartum was significantly associated with remission: 73% of the women had a postpartum onset, 15% had an onset during pregnancy, and 12% indicated that the onset was prior to the pregnancy. Among women with a postpartum onset, 46% were still symptomatic at 6 months, as compared with 77% of those for whom the onset had been during or before the pregnancy ($\chi^2 = 3.72$, $p = .05$). Furthermore, the nature of the diagnosis was
also related to remission. Only 20% of the women who were diagnosed with a depressive disorder were in remission at 6 months, whereas 44% of those with anxiety disorders and 74% of those with adjustment disorders had remitted by 6 months postpartum. Of the 15 fathers, 9 (60%) remained symptomatic at 6 months postpartum. Two of these fathers were lost to follow-up. Of the 17 fathers, 9 (60%) remained symptomatic at 6 months postpartum. In addition, three new cases were diagnosed at 6 months: two of these was −2.26 (p < .01). The model correctly classified 23 of 26 women who were still symptomatic (88.5%), and 14 of 22 women in remission (63.6%), for an overall classification rate of 77%.

**Psychological Symptoms in Mothers at 6 Months Postpartum**

We compared self-reported levels of psychological symptoms in the three groups of women: controls, those in remission, and those who continued to be symptomatic. Scores on the SCL90-R Anxiety, Depression, and Somatic Symptoms scales continued to be significantly elevated in the index group, whether or not they still met diagnostic criteria at 6 months postpartum (see Table 3). Repeated measures analysis of variance indicated significant main effects of diagnostic group (F[6,186] = 13.2, p < .001) and time of assessment (2 and 6 months postpartum; F[3,93] = 3.1, p < .05). Student-Newman-Keuls post-hoc comparisons indicated that the three groups of women were significantly different from one another in symptoms of anxiety and depression. The remitted and symptomatic women did not differ from each other in somatic symptoms, which were significantly elevated compared with controls. There was also a significant time × diagnostic group interaction effect for the anxiety scale (F[2,95] = 4.3, p < .05); women in remission showed a decrease in anxiety, whereas those who were still symptomatic did not.

Among the demographic variables, only maternal occupational status and country of origin were related to self-reported psychological symptoms on the SCL90-R. There was a significant effect of occupational status (F[3,94] = 4.4, p < .01) and somatic symptoms (F[3,94] = 5.7, p = .001). Student-Newman-Keuls post-hoc analyses indicated that women working in professional or managerial/white collar occupations had lower anxiety scores than those in lower status jobs, whereas somatic symptoms were elevated in women working in blue collar or unskilled jobs. Compared with native-born women, foreign-born women reported higher levels of depression (t[96] = 2.2, p < .05) and somatic symptoms (t[96] = 3.0, p < .01).

**Psychiatric Diagnoses in Fathers**

In the original sample, 17 fathers (24%) were diagnosed with a psychiatric disorder at 2 months postpartum. Two of these fathers were lost to follow-up. Of the 15 fathers, 9 (60%) remained symptomatic at 6 months postpartum. In addition, three new cases were diagnosed at 6 months: two of these

---

**TABLE 2**

Demographic Correlates of Remission in Mothers

<table>
<thead>
<tr>
<th></th>
<th>In Remission (N = 22)</th>
<th>Still Symptomatic (N = 26)</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean age (yr)</td>
<td>30.1</td>
<td>29.7</td>
<td>t(46) = −0.2 ns</td>
</tr>
<tr>
<td>Mean education (yr)</td>
<td>15.8</td>
<td>14.1</td>
<td>t(46) = −2.1*</td>
</tr>
<tr>
<td>% Working outside the home at time of infant's birth</td>
<td>55</td>
<td>58</td>
<td>χ² = 0.05 ns</td>
</tr>
<tr>
<td>% Working outside the home at 6 months postpartum</td>
<td>59</td>
<td>23</td>
<td>χ² = 6.5*</td>
</tr>
<tr>
<td>Occupational status (%)</td>
<td>Professional</td>
<td>41</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Managerial/white collar</td>
<td>23</td>
<td>31</td>
</tr>
<tr>
<td></td>
<td>Blue collar/unskilled</td>
<td>9</td>
<td>23</td>
</tr>
<tr>
<td>No occupation</td>
<td>27</td>
<td>42</td>
<td></td>
</tr>
<tr>
<td>% Primiparous</td>
<td>55</td>
<td>42</td>
<td>χ² = 0.7 ns</td>
</tr>
<tr>
<td>% Male infants</td>
<td>64</td>
<td>46</td>
<td>χ² = 1.5 ns</td>
</tr>
<tr>
<td>% Foreign-born women</td>
<td>56</td>
<td>33</td>
<td>χ² = 2.4 ns</td>
</tr>
</tbody>
</table>

*p < .05.

ns, not significant.
were the partners of index women who were still symptomatic at 6 months, and the third was in the control group. In contrast, among the remitted fathers, five were the partners of women who were also in remission, and the sixth was in the control group. It should be noted that in 23% of the couples where the woman had a diagnosis at 6 months postpartum, her partner also had a diagnosis; in contrast, only 8% of the women with no diagnosis had a partner with a diagnosis ($\chi^2 = 4.38, p = .05$).

Four of the six fathers in remission had had adjustment disorders, one an anxiety disorder, and one a major depressive disorder. The symptomatic group included three men with somatization disorders, three with mood disorders, two with generalized anxiety disorder, and one with an adjustment disorder.

Remission was unrelated to psychiatric history. As with the mothers, timing of onset of the disorder was significantly related to remission, with 83% of the fathers in remission reporting a postpartum onset and only 11% with an onset during or before the pregnancy ($\chi^2 = 7.82, p < .01$).

There were few demographic correlates of paternal mental health at 6 months postpartum. Infant gender, maternal parity, paternal age, education, and occupational status were also not associated with remission rates. Only country of origin was related to paternal psychiatric diagnosis, with 24% of the foreign born and 6% of the native born fathers having a current diagnosis at 6 months postpartum ($\chi^2 = 6.01, p < .05$). Fully 83% of the fathers in remission were native-born Canadians, as compared with only 22% of the fathers who were still symptomatic at 6 months ($\chi^2 = 5.40, p < .05$).

**Psychological Symptoms in Fathers**

Levels of psychological symptomatology differed according to the diagnostic group of the mothers (see Table 3). Repeated measures analysis of variance indicated a main between-subjects effect of diagnostic group ($F[6,184] = 2.3, p < .05$). Specifically, anxiety and depression scores were elevated among men in the index group, whether or not the women were in remission at 6 months. To determine whether symptom elevation could be attributed to men with a psychiatric diagnosis, we reanalyzed the data using only those fathers who did not have a current diagnosis. The results were virtually identical, indicating that even among fathers with no current diagnosis, those whose partners had a postpartum psychiatric disorder reported more symptoms. None of the demographic variables were related to psychological symptoms in the fathers at 6 months.

**Relationship between Life Stress, Psychiatric Diagnoses, and Psychological Symptoms**

Mothers in remission reported more life stress than either controls or mothers who were still symptomatic (see Table 4); the same was true for fathers. Life stress was found to be correlated (.26, $p < .01$) with maternal depressive symptoms on the SCL90-R, (.17, $p < .05$) with paternal depressive symptoms, and (.22, $p < .05$) with paternal somatic symptoms. These associations may help to explain why parents in remission continued to report high levels of

---

**TABLE 3**

*Mean Psychological Symptom T-Scores in Mothers and Fathers by Maternal Diagnostic Group*

<table>
<thead>
<tr>
<th>Maternal Symptoms</th>
<th>Control (N = 50)</th>
<th>Remitted (N = 22)</th>
<th>Symptomatic (N = 26)</th>
<th>Paternal Symptoms</th>
<th>Control (N = 50)</th>
<th>Remitted (N = 22)</th>
<th>Symptomatic (N = 25)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>47.5</td>
<td>52.7</td>
<td>64.4</td>
<td>50.3</td>
<td>55.4</td>
<td>58.6</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(10.0)a</td>
<td>(10.9)</td>
<td>(9.1)</td>
<td>(12.2)</td>
<td>(11.1)</td>
<td>(12.3)</td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td>51.4</td>
<td>59.2</td>
<td>65.9</td>
<td>52.2</td>
<td>59.2</td>
<td>60.1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(9.9)</td>
<td>(7.1)</td>
<td>(5.6)</td>
<td>(12.5)</td>
<td>(9.4)</td>
<td>(10.5)</td>
<td></td>
</tr>
<tr>
<td>Somatic symptoms</td>
<td>49.4</td>
<td>57.7</td>
<td>61.5</td>
<td>49.6</td>
<td>56.3</td>
<td>53.9</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(9.8)</td>
<td>(10.7)</td>
<td>(10.2)</td>
<td>(13.6)</td>
<td>(8.1)</td>
<td>(10.6)</td>
<td></td>
</tr>
</tbody>
</table>

* Standard deviations in parentheses.

---

**TABLE 4**

*Mean Scores on the Life Stress Scale for Mothers and Fathers by Diagnostic Groups*

<table>
<thead>
<tr>
<th>Maternal Diagnostic Group</th>
<th>Control</th>
<th>Remitted</th>
<th>Symptomatic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean life stress scores of mothers$^b$</td>
<td>7.5</td>
<td>13.0</td>
<td>8.9</td>
</tr>
<tr>
<td></td>
<td>(8.2)$^a$</td>
<td>(7.6)</td>
<td>(6.6)</td>
</tr>
<tr>
<td>Mean life stress scores of fathers$^c$</td>
<td>6.8</td>
<td>13.8</td>
<td>7.7</td>
</tr>
<tr>
<td></td>
<td>(7.6)</td>
<td>(8.0)</td>
<td>(5.4)</td>
</tr>
</tbody>
</table>

$^a$ Standard deviations are in parentheses.

$^b$ $F(2,94) = 3.9, p < .05$.

$^c$ $F(2,91) = 7.4, p < .001$. Data are missing for 1 control father and 2 fathers in the symptomatic group.
symptoms, even though they no longer met diagnostic criteria for a psychiatric disorder. However, analysis of covariance comparing women in the three diagnostic groups on depressive symptoms and controlling for life stress found that there continued to be a significant main effect of diagnostic group when life stress was taken into account ($F[2,93] = 24.22, p < .001$).

**Treatment for Mothers and Fathers with Postpartum Psychiatric Disorders**

Eighteen women and nine men had been referred for treatment; of these, 14 women and 6 men had actually received treatment. Thus, approximately one third of the parents with a postpartum psychiatric diagnosis had been referred for treatment, and only about a quarter had received treatment. All the men and 10 of the women were referred to either a psychologist, psychiatrist, or social worker. Other referrals for women were made to community health centers, a family physician, and a self-help group.

Demographic variables, including infant gender, parity, SES, and country of origin, were not related to either referrals or help-seeking among men and women. Diagnosis was not significantly associated with treatment, although referral was somewhat more likely to occur among women with depressive disorders (45%) than those with anxiety or adjustment disorders (22%). The same was true for men, with two thirds of those with mood disorders referred for treatment, compared with 22% of those with anxiety or somatic disorders.

The relationship between remission and treatment was also not statistically significant: 14% of the women in remission had received treatment, as compared with 31% of those who were still symptomatic. Similarly, 33% of the men in remission and 22% of those who were still symptomatic had received treatment. Given the small numbers of both men and women who had actually received treatment, we may have lacked the power to detect significant associations among variables relating to diagnosis, treatment, and remission.

**Discussion**

The results of this study of a community sample of postpartum women and their partners indicates that mental health problems tended to persist for several months after the birth of the infant. More than half the mothers and almost two thirds of the fathers who had a diagnosis at 2 months postpartum continued to meet diagnostic criteria at 6 months postpartum. Furthermore, even those who were in remission continued to report elevated symptoms of anxiety, depression, and somatic complaints.

Several factors were found to be related to persistent mental health problems among women in the postpartum period, including SES, type of diagnosis, and timing of onset of the disorder. Women of higher SES, as indexed by maternal education and occupational status, were more likely to be in remission at 6 months postpartum, as were those with a postpartum onset of the disorder. However, in multivariate analysis, only the nature of the diagnosis remained significantly associated with remission. Depressive disorders appeared to be particularly refractory, as compared with anxiety and adjustment disorders.

Country of origin may be another important risk factor for both men and women. Foreign-born women reported higher levels of psychological symptoms at 6 months postpartum, and foreign-born men had lower remission rates. Life stress and a lack of social support, which have been shown to be related to postpartum depression (cf. O’Hara, 1995) may be particularly important risk factors for depression in childbearing immigrant women (Zelkowitz et al., 2000).

The results of this study confirm other research showing that the partners of women with postpartum psychiatric disorders often exhibit mental health problems (cf. Harvey and McGrath, 1988; Lovestone and Kumar, 1993). Many of the fathers appeared to be suffering from chronic mental health problems, which continued to affect them after the birth of their children. However, even among fathers with no psychiatric diagnosis, those whose partners had a postpartum psychiatric disorder continued to report relatively high levels of psychological symptoms at 6 months postpartum. It is important to note as a limitation of this study that its findings cannot be generalized to the population of postpartum fathers, because the men were not screened directly for mental health problems, as were their partners. Routine screening of both partners in the postpartum period, and outreach to families suffering from mental health problems, is needed so that parents obtain the help and support they may need.

Life stress is a risk factor for postpartum depression (cf. O’Hara, 1995; Swendsen and Mazure, 2000); the results of this study indicate that stress was also related to the course of the disorder. It is of interest that parents in remission reported the highest levels of stress, which may serve to maintain elevated symptom levels. It is possible that mothers who are feeling better resume their regular activities, resulting in greater stress. For example, women in remission were more likely to have returned to work,
indicating that their functional status was more adequate than women who were still symptomatic. However, the return to work, and the need to combine family and job responsibilities, may be associated with greater stress for mothers of young infants.

The present study can only address the issue of treatment in a very limited fashion, due to small numbers and therefore inadequate power. It appears that we still have much to learn about the types of treatment that might be effective for postpartum psychiatric disorders. As noted above, few parents actually received treatment, and treatment was not found to be related to remission. There is little research on either pharmacological or psychosocial treatments (Nonacs and Cohen, 1998). There is a need to undertake clinical trials of different modalities of treatment, including psychopharmacological, cognitive-behavioral, interpersonal, and couple therapies. Because breastfeeding women may be reluctant to take psychotropic medication, demonstration of the efficacy of nonmedical treatments may afford service providers and clients more treatment options (Appleby et al., 1997).

This follow-up of a case-control study of postpartum women and their partners suggests that certain psychosocial and clinical variables are associated with persistent mental health problems. Because of the heterogeneity of diagnoses in the index group, it would be necessary to validate these findings in other cohorts, with larger numbers of women in the various diagnostic groups.

The results of this study indicate that for many families, postpartum psychiatric disorders are not a transient phenomenon. Evaluation, and even treatment, should include both partners, because the mental health problems of one spouse may affect the psychological well-being of the other. These are families at risk, where vulnerable parents are responsible for the care of the new infant, and in some cases other children as well. The extent to which these disorders affect family functioning needs to be addressed in future research.

References


