Postpartum assessment and nursing care
Low and high risk Puerperium
17th & 18th Lectures
The Puerperium (Postpartum Period)

- The time during which the body adjusts both physically and psychologically to having given birth. Begins immediately after childbirth and lasts for approximately six weeks, or until the body has completed its adjustment to a state of non pregnancy.

- Maternal changes period:
  1. Retrogressive: involution of the uterus and vagina
  2. Progressive:
     - Production of milk and lactation
     - Restoration of normal menstrual cycle
     - Beginning of parenting
Newborn Infants need

- Acceptance of
  - Sex, Appearance, Size
  - Recognition by the country (vital registration system)

- **Mother’s need Information/counseling on**
  - What happens in their bodies including signs of possible problems
  - Self care/hygiene and healing
  - Nutrition
  - Sexual Life
  - Care of the baby and breastfeeding
  - Contraception

dr. Shaban
Psychological Adaptation

1. The taking-in phase:

**Reflection:** during this 2- to 3-day period, the woman is largely passive. Woman usually wants to talk about her pregnancy, especially about her labor and birth. She prefers having a nurse make decisions for her.

**Abandonment** (Only hours before, they were the center of attention. Now, suddenly, the baby seems to be everyone's chief interest.

**Disappointment:** It can be difficult for parents to feel positive immediately about a child who does not meet their expectations in this way.

It is important to give the woman a chance to verbalize her feelings

Anticipatory stage: looks to role models
2. The taking-hold phase

- Occurs from the **third to the tenth day**. The mother assumes more responsibility and is more independent about herself and her infant once her basic needs have been met. Ready to receive health teaching and info.

**Women's need at this time**

- Give a woman brief demonstrations of baby care and then allow her to care for her child herself.
- Women who give birth without any anesthesia may reach this second phase in a matter of hours after birth. (also **Rooming-In**)

**Formal stage: influenced by the guidance of others**
3. The letting-go phase, or *interdependent phase*

- The mother begins to view the infant as a separate person. Some mothers have a difficult time with this concept and psychological problems can occur if this is not resolve. Roles may become disorganized relating to infant rearing, homemaking, and career.

**Informal (Personal) stage**: woman starts to make her own decisions and done what she is comfortable with.
Physiologic Changes
The Circulatory System

- Cardiac output is 60% to 80% higher than prelabor levels and remains elevated for at least 48 hours after delivery as a result to:
  1. The pressure of the pregnant uterus is eliminated, lead to increased blood return to the vena cava. The blood that supplied the uteroplacental vascular bed goes back into the systemic circulation. The rapid reduction in the size of the uterus causes a decrease in systemic vascular resistance.
  
- The blood volume has returned to its normal prepregnancy level by the first or second week after birth.

- Usual blood loss with a vaginal birth is 300 to 500 mL. With a cesarean birth, it is 500 to 1,000 mL.
**Vital Sign Changes**

- **BLOOD PRESSURE**: remain normal the first 24 hours after delivery. Orthostatic hypotension is caused by fainting on the client’s first ambulation, it is important to evaluate her stability.

- **PULSE**: usually decreases to the end of 1st week. Tachycardia over 100 indicate hypovolemic shock, fever, anxiety, pain, excitement, or physical exertion or medication.

- **Respiratory rate** usually will remain normal.

- **TEMPERATURE**: First 24 hours: slight increase related to dehydration during labor. After 24 hours a rise of above 38 degrees is febrile. A postpartum infection is suspected. On the 3rd to 4th day: a rise for a period of hours because of breasts filling with milk. If it lasts more -postpartum infection.
The Hormonal Changes & Menstrual Cycle:

- Pregnancy hormones begin to decrease as soon as the placenta is no longer present.
- By week 1, progesterone are at pre pregnancy levels.
- Follicle-stimulating hormone (FSH) remains low for about 12 days and then begins to rise as a new menstrual cycle is initiated.
- A woman who is not breast-feeding can expect her menstrual flow to return in 6 to 10 weeks after birth.
- If she is breast-feeding, menstrual flow may not return for 3 or 4 months (lactational amenorrhea)
- A woman may ovulate well before menstruation returns
POSTPARTUM NURSING ASSESSMENT

Done twice a day until discharge.

✓ The nurse must explain what is happening and what the mother can expect. At all times,
✓ The nurse maintains the mother’s privacy.
✓ Hand washing precedes any assessment & use nonsterile gloves and universal precautions to prevent contact with blood and other body fluids, including breast milk.

- **Assessment—“Bubble”**
  - **B**—Breasts **U**—Uterus **B**—Bladder **B**—Bowel
  - **L**—Lochia **E**—Epistomy/Extremities
Breast Changes —”Bubble”

- Postpartum assessment includes inspection and palpation of the mother’s breasts to determine lactation status.
- Breast size is influenced by the amount of adipose tissue and is unrelated to success in breastfeeding.
- Colostrum excrete in 1-2 days. Breast milk forms in response to the decrease in estrogen and progesterone (which stimulates prolactin production).
- Engorgement occurs by day 3 or 4. Due to vasoconstriction as milk production begins
Factors contributing to the success of breastfeeding

- The mother’s willingness to breastfeed. Many mothers do not feel comfortable exposing their breasts. Also, mothers may believe that breastfeeding interferes with their home and work routines, or may have had a negative experience in the past with lack of support.

- **Suppressing Lactation**

  Nonpharmacologic suppression, which is known as mechanical suppression (breast binder for at least 7 hours after delivery. Avoid any breast stimulation).

Dr. Shaban
Uterus—Involution —"Bubble"

- **Def:** reduction in the size of the uterus and its return to a condition similar to its prepregnant state.
- The fundus of the uterus palpated at the halfway between the umbilicus and the symphysis pubis, within a few minutes after birth.
- One hour later, it will have risen to the level of the umbilicus, where it remains for approximately the next 24 hours.
- Then, it decreases one fingerbreadth (1 cm) per day.
- By the ninth or tenth day, the uterus withdrawn into the pelvis and can't be detected by abdominal palpation.
To determine fundal position and height

- Ask the mother empty her bladder.
- Don nonsterile gloves
- Ask the mother to flex her legs and relax the abdominal muscles. This position will cause less discomfort during the procedure.
- To avoid inversion of the atonic uterus, place one hand above the symphysis pubis and gently support the lower segment of the uterus. Using the side of the other hand, locate the uterus and cup the hand over the fundus. Keeping the fingers flat and applying firm pressure downward toward the vagina, gently massage.
- If the mother is anxious, give an analgesic 15 to 20 minutes before the assessment or encourage the mother to use her labor breathing techniques.
Assessing the uterine fundus

- The nurse should determine Location, firmness/consistency of the uterine fundus
- Determination of the uterine fundal position and height
- Height/location is measured in fingerbreaths, above below or at the umbilicus. e.g @U, or U-2
- Consistency is documented as firm, soft or boggy
- If the uterus is “boggy” it should be massaged
UTERINE CONTRACTIONS

- known as after pains
- In Primigravidas, the uterus is in a tonic & in contracted state
- These after pains may be painful in the multipara mother, where some uterine tone has been lost and retraction cannot be attained as easily. Reassure the mother that the cramping is normal and will last for 3 to 4 days.
- Breastfeeding aggravates after pains
- The reasons why the uterus won’t contract (retained placenta, blood clots, or a full bladder.)
Nursing Interventions in case of After pain

- Lying in a prone position with a small pillow under the abdomen will help decrease the discomfort.
- Encourage the mother to empty her bladder before she breastfeeds. An empty bladder will allow the uterus to contract more efficiently and decreases the discomfort.

**Analgesia**: The nurse evaluates the effectiveness of the analgesia every 15 minutes until acceptable pain relief is achieved. Therefore, if the client has not achieved appropriate pain relief **within 30 minutes**, initiate nonpharmacologic pain measures that have not already been used such as distraction, heat, and a cold or warm shower.
Bladder-- Bubble

- **Diuresis** begins to take place almost immediately after birth to rid the body fluid.

- Pressure during vaginal birth may leave the bladder with a transient loss of tone that, together with the edema surrounding the urethra, decreases a woman's ability to sense when she has to void.

- Assessment reveals a dull sound heard on percussion

- **Diaphoresis** (excessive sweating) is another way by which the body rids itself of excess fluid. This is noticeable in women soon after birth.
Nursing Interventions in Urinary Elimination Problem

- Insure that there is adequate fluid intake
- Give an analgesia 15 to 20 minutes before she uses the bathroom.
- When the mother is sitting on the toilet, run warm water over her perineal area. This sensory input may stimulate voiding.
- Turn on the tap water to provide the sound of running water.
- Provide the mother with privacy and do not rush her.
- If the mother’s bladder is distended and she is unable to void after applying nursing measures, she needs to be catheterized
- Remember, when a catheterization is performed, to remove no more than 800–900 cc of urine to avoid a precipitous drop in the intraabdominal pressure, which may lead to a splanchnic engorgement.
Almost immediately, the woman feels hungry and thirsty because of restricted fluid during labor and the beginning diaphoresis.

**Hemorrhoids** (distended rectal veins) due to the effort of pelvic-stage pushing often are present. Hemorrhoids are treated only if they become symptomatic, develop external thromboses, or prolepses and develop internal bleeding. Hemorrhoids will often disappear within a few weeks after delivery.

Bowel sounds are active, but passage of stool through the bowel may be slow because of the still-present effect of relaxin on the bowel.

Bowel evacuation may be difficult due to the pain of episiotomy sutures or hemorrhoids
Nursing Interventions in Bowel Elimination Problem

- Encourage ambulation.
- Provide Fiber include fruits, vegetables, grains, and bran.
- The mother should increase her fluid intake to at least 8 to 10 glasses of water a day.
- Stool softeners a suppository may be necessary to return normal bowel function.
- **Interventions for hemorrhoids** include a sitz bath two or three times a day for 20 minutes. Adding Epsom salts to the water.
- Instruct the mother to avoid prolonged sitting and alternate sitting positions. Hemorrhoid cream, ice, anesthetic sprays.
Lochia – Bubble

- Uterine flow, consisting of blood, fragments of decidua, WBCs, mucus, and some bacteria
- **Characteristics of Lochia**
  - **Lochia rubra:** Red 1–3 Blood, fragments of decidua, and mucus
  - **Lochia serosa:** Pink 4–9 Blood, mucus, and invading leukocytes
  - **Lochia alba:** White 10–14 (may last 6 weeks) Largely mucus; leukocyte count high

120 ml of lochia may be discharged without any effect on the mother. After the first postpartum hour, the volume of the lochia gradually diminishes. The total volume of lochia is approximately 240 to 470 ml.
When Lochia Increased

- Vaginal pooling can occur with the first ambulation after delivery and with the first ambulation in the morning. Reassure the mother that it is common to get a gush when she first gets out of bed and provide her with a pad to catch the blood.

- Remember to observe the lochia on the peri pad and the bed linen under the mother’s buttocks. Even though there may be a small amount of blood on the front of the peri pad.
Assessment of lochia blood loss

- Lochia is assessed for amount, odor, and whether there are any clots present.

- Estimation of the amount of lochia is commonly described as:
  - **Scant** - less than a 1 inch stain on the perinal pad
  - **Small** - smaller than a 4 inch stain
  - **Moderate** - smaller than a 6 inch stain
  - **Heavy** - larger than a 6 inch stain
  - **Excessive** - pad saturation within 15 mins
EPISIOTOMY -- Bubble

- The episiotomy site is usually well healed in 2 to 3 weeks.
- The side effects of an episiotomy is infection, increased pain, longer healing time and increased discomfort when intercourse is resumed.
- LACERATIONS

- The nurse needs to assess the condition of the perineum. The acronym REEDA is used to describe what to look for when performing the assessment (redness, edema, ecchymosis, discharge, and approximation of sutures).
To examine the perineum

- Ask the woman lie in the Sim’s position (on her left side with the right knee and thigh drawn upward toward the chest).
- Wear nonsterile gloves for optimal protection.
- Make sure there is good lighting for adequate observation.
- Gently lift the buttocks to expose the perineum and the anus. Use this assessment time to educate the mother and explain your findings. Explain to the mother that the sutures will dissolve slowly over the next few weeks.
- The perineal area is commonly assessed immediately after delivery, then every 15 minutes over the next hour.
Mild perineal edema, labial swelling and the introitus (the entrance to the vagina) may be edematous, and ecchymotic.

Estrogen levels are decreased for 3 to 4 weeks after delivery. This results in atrophic changes such as decreased vaginal lubrication (localized dryness and discomfort during intercourse) and diminished sexual responsiveness.

This usually resolves without intervention by 6 to 8 weeks after delivery, when normal hormone balance is reestablished.
Nursing Diagnosis

- **Risk for fluid volume deficient** related to postpartal hemorrhage
- **Pain** related to uterine cramping (afterpains) or perineal sutures
- **Risk for infection** (uterine) related to lochia and episiotomy
- **Disturbed sleep pattern** related to exhaustion from and excitement of childbirth
- **Risk for bathing/hygiene self-care deficit** related to exhaustion from childbirth
- **Risk for impaired urinary elimination or constipation** related to loss of bladder and bowel sensation after childbirth
Nursing interventions in the postpartum period

- Assess funal locations height and consistency
- Massage fundus if boggy or soft
- Monitor vital signs, Assess lochia
- Assess perineum, apply ice packs or anesthetic sprays to perineum, Provide sitz baths
- Providing guidance about sexuality and FP
- Scheduling follow-up for newborn and mother
- Assess breasts- provide breast pump if needed
- Administer pain medication as ordered
- Promote ambulation
- Monitor urinary output- encourage fluids and high fiber, administer stool softener
- Encourage mother-infant bonding
- Performing discharge teaching
Time for assessment of vital signs

- Every 15 minutes during the first hour after delivery unless the mother’s condition warrants assessment more frequently.
- Once transferred to postpartum, every hour until stable. Usually for 2 hours.
- During the first 24 hours after delivery, vital signs usually assessed every 4 hours.
- After 24 hours, at the beginning of each shift until discharge.
Rest

- Fatigue must be relieved to promote healing and to promote milk production in the lactating mother.
- Fatigue can magnify negative emotional sensations, including depression, frustration, or feelings of inadequacy. Therefore, it is important that the father and/or family members support the mother. Once the mother is rested and rebuilds her energy she will be able to take over more responsibilities.
- Nursing interventions include asking the family to leave so the mother can rest, and instructing the mother to nap while the infant is asleep. Hospital and nursing routines may be adjusted to meet individual needs. Instruct the mother to notify the nurse if she has specific needs.
Ambulation

- Early ambulation encourages elimination, decreases the discomforts associated with delivery, and promotes rapid recovery & lower the incidence of thromboembolism.
- A woman who has had an uncomplicated delivery may ambulate to the bathroom to void and take a shower within one hour if her vital signs, lochia, and fundus are within the normal range. A woman that has had an epidural should be kept in bed until she is fully able to move and feel sensation in her legs.
- Therefore, before ambulation, evaluate vital signs, amount of blood loss during delivery, level of consciousness. A client may need to be encouraged to ambulate if she has not voided in 6 hours.
Diaphoresis

- Episodes of diaphoresis occurring more frequently at night, soaking gowns and bed linens. **Linen change and frequent showers provide comfort and rest.** Profuse diaphoresis is not significant unless the mother has a temperature, where in infection should be ruled out.

- The rapid diuresis and diaphoresis during the second to fifth days after birth usually result in a weight loss 2 to 4 kg. In addition to 6 kg lost at birth. Lochia flow causes an additional 1-kg loss, for a total weight loss of about 12 kg.

- Additional weight loss is most dependent on the amount of pregnancy weight gain, nutrition, exercise, and breast-feeding. The weight a woman reaches at **6 weeks** after birth becomes her baseline postpartal weight.
Discharge teaching

- **Rest** when infant is sleeping
- **Hygiene:** A woman may take either tub baths or showers. cleanse her perineum from front to back. Any perineal stitches will be absorbed within 10 days.
- **Avoid heaving lifting** or heavy house work for 4 weeks, Limit exercise and activities
- **Sexual intercourse** is avoided for 4-6 weeks, a lubricant should be used
- **Use of a contraceptive**
- **Follow up** with MD in about 4-6 weeks
- Exercise Beginning the second week, if her lochial discharge is normal, she may start to increase this activity.
Postpartum danger signs to report

- Fever
- Change in vaginal discharge
- Localized area of pain, redness, swelling in breast
- Pain in the abdomen or pelvic area
- Pain, swelling or warm area in the calf of leg
- Persistent perineal pain
- Frequency, urgency or burning on urination
- Continued postpartum depression
Postpartum complications

- Postpartum complications fall into five categories
  - Hemorrhage
  - Thromboembolic disorders
  - Subinvolution of the uterus
  - Infections
  - Depression
Postpartum Hemorrhage

- greater than 500cc blood loss (vaginal delivery) or 1000cc blood loss (cesarean)
- Postpartum hemorrhage can occur
  - Within the first 24 hours
  - After 24 hours to less than 6 weeks after birth
Causes of postpartum hemorrhage

- **Early postpartum hemorrhage**
  - Uterine atony & lacerations

- **Late postpartum hemorrhage**
  - Retained placenta fragments or organized blood clots

**Causes (the four T’s):**
- Tone
- Trauma
- Tissue
- Thrombin
Postpartum Hemorrhage: Tone - Uterine atony

- Inability of the muscles of the uterus to contract and stay contracted around the open blood vessels from the placenta site

- **Risk Factors:**
  - uterine overdistension (hydramnios, multiple gestation, oxytocin use, macrosomia)
  - high parity
  - prolonged labor
  - intramnionic infection
  - Full bladder
Postpartum Hemorrhage: Trauma

- Vaginal, cervical, perineal lacerations with firm uterus
- **S&S.** Bright red bleeding from the genital tract
- **Types**
  - uterine inversion, uterine rupture
  - birth canal trauma

**Treatment:** lacerations: repair
- Hematomas (<3cm may observe if stable, if larger or unstable, incise and evacuate clot, ligate vessels, close in layers)
Postpartum Hemorrhage: Tissue

- **Etiology**
  - retained placenta
  - invasive placenta
  - **Accreta**: Adherent to myometrium
  - **Increta**: Invades myometrium
  - **Percreta**: Penetrates myometrium

- **Risk Factors**
  - previous peripartum curettage
  - previous cesarean
  - placenta previa
  - high parity
Nursing interventions for PP hemorrhage

- Uterine massage
- Insert large bore IV canula
- IV fluids, IV oxytocin, Methergine
- Obtain blood for xmatching, CBC and clotting times
- Insert Foley record I&O, Keep bladder empty
- Apply pulse oxyimetry
- Monitor vital signs
- Administer oxygen
- Elevate legs to 20-30 d.
- Explain procedures to woman
- Provide emotional support
Thrombophlebitis & DVT

- **Signs & symptoms**
  - Pain, redness, swelling, heat and tenderness in the calves of the feet
  - Positive homan’s sign
  - Fever and chills
  - Increased diameter of the affected leg
  - Leg pain extending above the knee (DVT)

- **Nursing care**
  - Rest, Analgesics
  - Elevation of the leg
  - If DVT is diagnosed administer anticoagulant therapy
  - Observe for signs of bleeding from over coagulation
Pulmonary embolism

- **Signs & symptoms**
  - Complication of DVT
  - Abdominal pains
  - Chest pain
  - Dyspnea
  - Tachypnea
  - Hypotension

- **Nursing care**
  - Elevate the head of the bed
  - Administer oxygen
  - Apply pulse oxymetry
  - Iv fluids
  - Initiation of heparin
  - Bed rest
  - Frequent vital signs
Postpartum infections

- Puerperal infections (infections of the reproductive tract)
  - Endometritis

- Nonreproductive infections include
  - Wound infections
  - Urinary tract infections
  - Breast infections - mastitis
Major sign for PP Infection

- WBC normally 20-30,000/mm³ so its not great value to detect infection during puerperium.

- Increased Oral temp. above 38°C for two consecutive 24-hour periods, excluding 1st 24hr after birth

- Chills; loss of appetite, and general malaise
Endometritis

The most common cause of uterine infection is bacteria moving from the vagina to the uterus. The delivery of the placenta leaves an open, raw decidual site. After the delivery the cervix is open and at risk for an ascending infection.

*It is dangerous for a woman to assume a knee-chest position until at least the third week after birth.* In a knee-chest position, the vagina tends to open. The cervical os remains open, there is a danger that air will enter the vagina and the open cervix, penetrate the open blood sinuses inside the uterus, enter the circulatory system, and cause an air embolism.
Endometritis

- **Signs & symptoms**
  - Uterine tenderness and enlargement
  - Foul odor or purulent lochia
  - Malaise, Fatigue
  - Tachycardia
  - High Temperature

- **Nursing care/treatment**
  - Antibiotics
  - Antipyretics
  - Analgesics
  - Fowlers position to promote drainage of lochia
  - Encourage increased fluid intake and nutrition.
PREVENTION

- Hand washing and maintenance of a clean environment.
- Visitors, including siblings, who are sick must be encouraged to stay home.
- The bed and/or bed pads should be changed when soiled.
- The mother is asked not to walk barefooted. When the mother walks barefooted, she picks up bacteria off the floor and contaminates the bed linens when she gets into bed.
- Encourage proper care of the perineal area, using front-to-back wiping, and changing the peri pad after using the bathroom.
Postpartum Fever (wound/perineal infections)

- **Wound infections**
  - cesarean incision infection rate 3 to 15%, decreases to 2% with prophylactic antibiotics
  - infections usually polymicrobial

- **Perineal infections**
  - treatment: debridement, removal of sutures, drainage, antibiotics
  - complications: necrotizing fasciitis, sepsis
Urinary tract infections

- Urinary frequency, urgency
- Subrapubic pain dysuria
- Hematuria
- Pyelonephritis
- Fever; chills, loin back pain
- Nausea and vomiting

Nursing care

- Vital signs
- Increase fluid intake to 3000ml
- Antipyretics
- Analgesics
- Antibiotics
- Ascorbic acid
Mastitis

**Signs & symptoms**
- Painful or tender localized hard mass and reddened area usually of one breast
- Enlarged glands in the axilla
- Fever, chills, malaise

**Nursing care**
- Antibiotics
- Instruct mother to continue to breastfeed
- Instruct to completely empty each breast after feedings
- Wear a well supporting properly fitted bra
- Apply Ice packs or warm packs to the affected breast

---

dr. Shaban
Self care for mastitis

- Wash hands thoroughly before breast feeding
- Maintain cleanliness
- Expose nipples to air
- Correct infant latch-on and removal from breast
- Encourage infant to empty the breast
- Frequently breast feed to promote mild production

- If an area of the breast is distended or tender breast feed form the unaffected side first at each feeding
- Report redness or fever
- Apply ice packs or moist heat to relieve discomfort.

dr. Shaban
Postpartum Blues

- The syndrome is evidenced by tearfulness, feelings of inadequacy, Transient & mild mood swings w/ irritability, anxiety, poor concentration, anorexia, and sleep disturbance.
- **Incidence** is 40-80% of PP women within 2-3 days of delivery, peaking on Day # 5, resolving within 2 weeks
- **Risk factors** include H/O depression or pre-existing psychosocial impairment, hormonal changes, although fatigue, discomfort, and overstimulation may play a part.
- **Nursing Role**: Reassure a woman and her support person that sudden crying episodes are normal, give the woman a chance to verbalize her feelings.
Postpartum Psychosis

- **Incidence** is 0.1-0.2%
- Typically presents within 2 weeks of delivery w/ mania, depression or schizoaffective disorder. Delusions, hurting self or the infant, insomnia, suspiciousness, confusion, obsessive concerns regarding the baby
- This is a **MEDICAL EMERGENCY** which mandates an immediate psychiatric consult
- Patient should be hospitalized until stable
- While psychotic, mom cannot adequately care for self or infant, not be able to continue breastfeeding
- Combination therapy (Medications & psychotherapy
Postpartum Depression

**Onset** within first month PP

Incidence 5-9% (similar to that in non-pregnant women), but may be under-reported

**Risk factors** include antenatal depression or psychiatric FH, marital conflict, unplanned pregnancy, congenital fetal ABNL’s

**Etiology** is probably multifactorial: genetic susceptibility, hormonal changes, major life stressors.

**Symptoms** include changes in somatic functions (sleep, energy, appetite, weight, GI fcn., insomnia unrelated to newborn’s sleep pattern), guilt, anxiety, anger, loss of bonding w/ newborn, and obsessional thoughts of harming oneself or baby. Intense sadness, crying all the time, mood swings, fears, anger, anxiety, irritability (Screening w/ Edinburgh PP
# Comparing Postpartal Blues, Depression, and Psychosis

<table>
<thead>
<tr>
<th></th>
<th>Postpartal Blues</th>
<th>Postpartal Depression</th>
<th>Postpartal Psychosis</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Onset</strong></td>
<td>1&lt;sup&gt;st&lt;/sup&gt; week after birth</td>
<td>1-12 months after birth</td>
<td>2-4 weeks after birth</td>
</tr>
<tr>
<td><strong>Symptoms</strong></td>
<td>Sadness, tears</td>
<td>Anxiety, feeling of loss, sadness</td>
<td>Delusions or hallucinations of harming infant or self</td>
</tr>
<tr>
<td><strong>Incidence</strong></td>
<td>70% of all births</td>
<td>10% of all births</td>
<td>1%-2% of all births</td>
</tr>
<tr>
<td><strong>Therapy</strong></td>
<td>Support, empathy</td>
<td>Counseling, drug therapy</td>
<td>Psychotherapy, drug therapy</td>
</tr>
<tr>
<td><strong>Nursing role</strong></td>
<td>Offering understanding</td>
<td>Referring to counseling</td>
<td>safeguarding mother from injury to self or to newborn</td>
</tr>
</tbody>
</table>

*dr. Shaban*
Treatment

- Psychosocial therapies
  - First choice for those with mild to moderate symptoms of PPD, Cognitive-behavioral therapy
  - Interpersonal psychotherapy - focuses on patient’s interpersonal relationship and changing roles
- Group therapy
  - Helps to increase support network
- Family and marital therapy
  - More rapid recovery
- Peer-support groups