POSTPARTUM DEPRESSION:
A Guide for Patients and Families

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The birth of a baby is generally considered a joyful time, but it is also a time when women are susceptible to depression. Such feelings make it very hard for a new mother to take care of herself and her baby and put strain on the family. Depression that occurs after the birth of a baby is called "postpartum" depression. If you or someone you love is suffering from postpartum depression, you probably have questions about why this is happening and how to help, questions this guide is intended to answer.

What is Postpartum Depression?

There are 2 main kinds of postpartum depression:

- postpartum or maternity "blues," a mild mood problem of short duration
- postpartum major depression, a severe and potentially life-threatening illness.

What are the postpartum blues?

Postpartum blues affect 50%–80% of new mothers. Symptoms usually begin 3–4 days after delivery, worsen by days 5–7, and tend to go away by day 12. The new mother may have mood swings with times of feeling tearful, anxious, or irritable, interspersed with times of feeling well; and she may have trouble sleeping. If symptoms last longer than 2 weeks, it is important to seek medical attention, since 1 in 5 women (20%) with postpartum blues goes on to develop postpartum major depression.

What is postpartum major depression?

Postpartum major depression can begin anytime in the first days or weeks after delivery and is far more serious than postpartum blues. It is a type of mood disorder, a biological illness caused by changes in brain chemistry, and is not the mother's fault or the result of a "weak" or unstable personality. It is a medical illness which professional treatment can help. The symptoms of postpartum major depression include a depressed mood most of the day, nearly every day, for at least 2 weeks and losing interest or pleasure in activities one used to enjoy. Other symptoms include fatigue, feeling restless or slowed down, a sense of guilt or worthlessness, difficulty concentrating, insomnia, and recurring thoughts of death or suicide. The woman may also be very anxious about her baby's health. Some women with very severe postpartum depression develop psychotic thoughts (hallucinations or delusions), and there is a small but real chance that they could harm their children.

About 10%–15% of new mothers develop postpartum major depression, but it is often not diagnosed until several months after the birth. Sometimes the new mother puts off seeking medical help because of lack of energy caused by the illness or fear of what others will think. The new mother may feel guilty about being depressed when she is supposed to be happy. Family members and physicians may also fail to recognize the symptoms as depression, believing instead that the mother's mood is a normal reaction to the stress of caring for the infant.

What causes Postpartum Depression?

We don't know exactly what causes postpartum depression, but research points toward hormonal factors that may in turn affect brain chemistry. At the time of birth, the amount of estrogen and progesterone in the bloodstream and brain fall suddenly. Women who develop postpartum depression may be especially sensitive to this change as the body returns to its "normal" balance. Another important, though infrequent, cause of depression is an underactive thyroid gland after delivery, a

problem that is relatively easy to treat if detected. Research is being done to find out about other biological and social problems that may be involved. The brain chemistry of postpartum depression is probably similar to abnormalities that researchers believe are present in other types of depression. This view is supported by the fact that postpartum depression occurs more often in women who have had depressions at other times or have close relatives with depression (where there may be a hereditary factor).

Who is at risk for postpartum major depression?

The most important risk factor for postpartum depression is having had a similar episode before. Over half of the women who have had a previous depression after the birth of a child will become depressed again when they give birth. If a woman has been depressed at any other time in her life, her risk of developing a postpartum depression also increases, from about 10% (risk for a woman with no history of depression) to 25%. Women with manic-depressive illness (also known as bipolar disorder) are also at very high risk. Women are also more vulnerable if they have been depressed during pregnancy, if they had significant premenstrual mood symptoms before they were pregnant, or if they have close relatives with depression or bipolar disorder. It is very important for a woman with a personal or family history of a mood disorder to talk to her doctor so that she can be monitored closely. Stressful situations (e.g., health problems in the baby, marital discord, not having a partner) may also place a woman at an increased risk for postpartum major depression.

Will untreated postpartum depression affect the baby?

Studies of depressed mothers have shown that postpartum depression can have significant negative effects on the baby that can persist into childhood. Mothers who are depressed may be less involved with their children. When interactions between mother and infant are impaired, this can have an effect on the child's later behavior. Studies have shown that such children may not perform as well on some developmental tasks as children of mothers who were not depressed. Their ability to

interact with other children may also be affected, and they may have behavioral and learning problems. It is therefore very important to identify and treat postpartum depression as early as possible.

How is Postpartum Depression treated?

Treatment for postpartum depression depends on the severity of the symptoms. By definition, postpartum blues last only a few days to as much as 2 weeks. With extra help caring for the newborn and emotional support for the mother, these feelings usually pass quickly. However, when depression deepens and persists for more than a short time, more active treatment is needed. If the depression remains mild enough for the woman to function, she may benefit from skilled psychotherapy. However, if there are clear symptoms of more severe major depression, experts recommend combining carefully selected antidepressant medication with counseling and support. Information has been gathered on the effects of several antidepressants on breast-fed infants, showing no evidence of serious problems. The more severe the depression, the more strongly the experts urge the use of medication.

If a woman has very severe symptoms, such as suicidal or psychotic thoughts, the doctor may need to put her in the hospital to ensure her safety and that of the baby while her symptoms are addressed. Electroconvulsive therapy is an alternative to consider if a mother does not respond to medication or is breast-feeding and wants to avoid medication.

Antidepressant Medications

Many different kinds of antidepressants are available with different chemical actions and side effects. All of them treat depressive symptoms and may be helpful for postpartum depression. A mother who is breast-feeding, however, may be concerned about the safety of antidepressant medication for her infant. For postpartum depression in a breast-feeding mother, the experts recommend medications called **serotonin reuptake inhibitors** (SSRIs), which affect the brain

chemical, serotonin. Their top choice among these is sertraline (Zoloft), the most widely studied antidepressant in breast-feeding mothers and their infants. While small amounts enter breast milk, little or no medication can be detected in infants, and there appear to be no adverse effects. Paroxetine (Paxil) is also a highly-rated choice. Paroxetine is not detectable in breast milk or nursing infants. Two other widely used SSRIs, fluoxetine (Prozac) and citalopram (Celexa), enter breast milk in small amounts but are viewed as acceptable alternatives. If a mother took fluoxetine or citalopram during her pregnancy and needs to stay on medication after delivery, experts do not think it is necessary to change to another drug. Tricyclic antidepressants, an older type of medication, are also viewed by experts as an appropriate choice for breast-feeding mothers. Imipramine (Tofranil) and nortriptyline (Pamelor) are 2 examples. Tricyclics usually cause more side effects in the mother than SSRIs but are sometimes more effective. If the baby has health problems, the pediatrician can obtain a blood sample to see if the antidepressant is present in the baby in a significant amount and might be contributing to the problem.

For an extremely severe type of depression in which the mother has psychotic symptoms (hallucinations or delusions), it is important to combine the antidepressant with another kind of medication called an antipsychotic. If the mother is breast-feeding, the experts recommend an older type called conventional antipsychotics (such as Haldol); newer types (atypical antipsychotics such as Risperdal or Zyprexa) are preferred otherwise, but have not been tested enough in breast-feeding mothers and their infants.

Psychological treatments: counseling and support

For a woman with postpartum major depression, experts recommend household help and therapy with a mental health professional. If depression is severe, the experts urge finding someone to stay with and assist the mother at all times, such as a relative, friend, or paid helper. Family and friends can offer non-judgmental support, reassurance, hope, and validation of the new mother’s abilities. Common

issues in psychotherapy for postpartum depression include overwhelming fears about new responsibilities and guilt over becoming depressed at such a crucial time. Two techniques that treat depression by putting these problems in perspective are interpersonal therapy and cognitive-behavioral therapy. It is usually valuable to include the spouse or other main caretaker in therapy to help him or her understand the symptoms of depression and cope with the increased stress on the family.

Preventing postpartum depression

Previous episodes of depression increase the risk that a woman will develop postpartum depression. The risk is highest in a woman who has actually had postpartum depression after an earlier pregnancy. If a woman has a history of depression, her doctor may discuss treatments to lower the chance it will return after delivery. If this is her first pregnancy and she has felt well throughout with no treatment, most experts suggest careful monitoring but no new treatment unless symptoms appear. However, if a woman has had postpartum depression in the past, most experts recommend beginning preventive treatment with antidepressant medication and psychosocial interventions right after delivery. Some experts would start a preventive program during the mother's third trimester if she is at very high risk. A typical plan might be to begin psychotherapy 2–3 months before the due date and then add antidepressant medication in the final few weeks when there is almost no risk to the fetus.

Support Networks

Support groups can be very helpful for women with postpartum depression or other emotional problems after the birth of a baby. These groups can help a woman feel less alone, learn new coping skills, and find out about local resources.

Postpartum Support International
927 North Kellog Ave.
Santa Barbara, CA 93111
(805) 967-7636
http://www.postpartum.net

Depression After Delivery
91 East Somerset St.
Raritan, NJ 08869-2129
(800) 944-4PPD (to request information packet)
An excellent web site with lots of information, resources, and links:
http://www.depressionafterdelivery.com