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Beyond the "baby blues"

Postpartum depression is common and treatable.

Most mothers experience the "baby blues" during the first few weeks after giving birth. Telltale symptoms such as anxiety, irritability, and weepiness typically worsen by the fourth or fifth day after delivery and subside on their own within two weeks.

An unfortunate few develop postpartum psychosis. This rare but life-threatening disorder requires immediate treatment (see "Postpartum psychosis," page 3).

Postpartum depression lies somewhere in between these two states. This disorder affects about 10% to 15% of mothers, whose "baby blues" turn into something more persistent. A mother with postpartum depression may feel sad, worthless, or guilty. She may be unable to concentrate or take interest in anything, even her baby (see "Symptoms of postpartum depression," page 2).

Postpartum depression also affects men. One recent analysis estimated that as many as 10% of fathers develop postpartum depression within the first year after the birth of a child.

Although postpartum depression is surprisingly common, those affected may be embarrassed about feeling depressed and overwhelmed at what is supposed to be one of the happiest times of their lives. As a result, many people are reluctant to seek help. Fewer than half of women with postpartum depression seek treatment.

Lack of treatment for postpartum depression can take a toll not only on a parent's mental health, but also on a child's development. In some cases, offspring of parents with any kind of untreated depression suffer delays in cognitive development, take longer to mature emotionally, or develop depression themselves. Fortunately, multiple treatment options exist for postpartum depression.

Causes and risk factors

Postpartum depression is a form of major depression. Both develop because of a combination of biological vulnerability, psychological factors, and life stressors.

During evaluation, it's important for a clinician to rule out other medical problems that could cause symptoms similar to those of postpartum depression. One possibility is anemia, a common complication of pregnancy caused by a deficiency in oxygen-carrying red blood cells. Anemia can cause fatigue and depression, but it is easily treated with dietary changes or iron supplements.

Less often, a thyroid deficiency may be to blame for postpartum symptoms. Pregnancy sometimes causes the thyroid gland to become underactive, bringing mood and energy levels down. Treatment usually involves taking a daily hormone supplement to restore levels to normal.

Aside from other medical problems, the following factors may contribute to the development of postpartum depression.

Hormone fluctuations. During pregnancy, a woman's levels of estrogen and progesterone both rise dramatically. These hormones help the uterus to expand, maintain the uterine lining, and help sustain the placenta (the organ that provides the fetus with nutrients). Within 48 hours after delivery, however, levels of estrogen and progesterone plummet. Because these reproductive hormones also interact with neurotransmitter systems that affect mood, this postpartum hormonal crash can cause emotional instability in women whose biology makes them more vulnerable to the changes. In addition, regulation of stress hormones may be disrupted during pregnancy and in the postpartum period, adding to a woman's distress. ▸▸

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Prior depression. Women and men who have developed any type of depression in the past are more vulnerable to postpartum depression than other people. For example, 10% of women who have never been depressed develop postpartum depression, compared with 25% of those who have been depressed. And at least 50% of women who recover from one episode of postpartum depression experience a relapse of symptoms after another delivery.

Stress. Pregnancy, childbirth, and becoming a parent are all stressful experiences that can, on their own, precipitate postpartum depression. Expectant or new parents who experience additional life stressors—such as the loss of a job, a financial setback, or the death of a loved one—may be even more vulnerable to developing this disorder.

Fatigue. All parents of newborns get less sleep than normal, but people who develop postpartum depression may be the most sleep-deprived of all. It is hard to determine whether symptoms of postpartum depression might be due to lack of sleep, to depression, or to some mix of the two. As one paper on the topic put it, are women "sleepy or weepy?" The answer may be both. One study found that sleep disturbance alone—even after controlling for other risk factors—increased women's likelihood of developing postpartum depression.

Lack of support. Marital conflicts and social isolation increase the chances that parents will develop postpartum depression. Parents who do not have a circle of friends and family to help support them emotionally—or help out with child care—are also prone to postpartum depression.

Prevention

It is possible to reduce the chances of developing postpartum depression. A good first step for expectant parents is to seek out friends, family, or other support networks (such as church groups or social media) in advance of the delivery date. That way, once a child is born, the parents will have somewhere to turn for practical advice or to get help with child care.

And while getting a good night's sleep may seem impossible for parents caring for a newborn, it makes sense to do anything possible to improve the odds. One practical strategy is to walk every morning with the baby in a stroller, so that both parent and infant are exposed to natural light, which can help establish wake-and-sleep circadian rhythms. Parents should also try to take naps during the daytime, whenever possible, to make up for sleep deprivation caused by night feedings.

People who are at particularly high risk for postpartum depression—such as those who have had postpartum depression in the past—may want to take additional steps to protect themselves. Options to consider include psychotherapy and medication, using the same modalities used to treat any depression, as discussed below.

Symptoms of postpartum depression

Parents should consult a clinician about postpartum depression when any one of the following symptoms occurs most of the time nearly every day and continues for at least two weeks. If thoughts of suicide occur, seek help immediately.

- depressed mood, sadness
- crying spells
- loss of interest in daily activities
- feelings of guilt or worthlessness
- fatigue, reduced energy (beyond what typically occurs when caring for a newborn)
- sleeping problems
- change in appetite
- inability to concentrate
- thoughts of suicide

Treatment

Treatment options for postpartum depression depend on severity of symptoms and personal preference.

Psychotherapy. When symptoms of postpartum depression are mild or moderate, psychotherapy alone may improve mood. Cognitive behavioral therapy can help people learn to reframe the way they think about the postpartum experience—perhaps by adjusting expectations—in order to reduce stress and improve mood. Psychodynamic, insight-oriented, and interpersonal therapy focus more on the quality of relationships and help people sort out conflicts or understand how past experiences can affect symptoms. Couples therapy can help when marital difficulties are preventing parents from resolving disagreements or responding to the child's needs.

Antidepressants. A variety of antidepressants help alleviate symptoms of moderate to severe postpartum depression. In men or in women who are not breast-feeding, drug choice depends on symptoms, personal preference, and side effects. For example, selective serotonin reuptake inhibitors (SSRIs) such as sertraline (Zoloft) or venlafaxine (Effexor) are unlikely to cause sedation (a plus for parents who are already struggling to stay awake because they are sleep-deprived), but can cause sexual problems such as loss of libido or trouble reaching orgasm. Tricyclic antidepressants such as imipramine (Tofranil) or nortriptyline (Pamelor) make people sleepy, but that could be desirable for people who experience insomnia as part of postpartum depression. Yet another option is bupropion (Wellbutrin), a newer antidepressant that works in a different way from other antidepressants and may help if other drugs have not.

Women who want to breast-feed can take antidepressants during the postpartum period. Although all psychiatric medications are secreted into breast milk, some are not passed on to the infant, or are passed on at such low levels that doctors consider them relatively safe. The research suggests that the safest choices for breast-feeding mothers include the SSRI sertraline and the tricyclic antidepressant nortriptyline.

A wise strategy for a nursing mother is to start an antidepressant at the lowest possible dose and increase dose only as necessary, while watching the infant for signs of adverse reactions—such as irritability, grogginess, failure to gain weight, or changes in feeding schedule. Infants most vulnerable to drug reactions are those younger than 8 weeks, those who were born prematurely, and those with other medical problems.

Electroconvulsive therapy. When symptoms of postpartum depression are severe, when postpartum psychosis occurs, or when suicide is a possibility, electroconvulsive therapy (ECT) may be a sensible choice because it is effective and works faster than drugs (see *Harvard Mental Health Letter*, January 2009). While sedated, a patient undergoing ECT receives a short-acting anesthetic to prevent awareness of the procedure and to reduce discomfort. Once the patient is sleeping, the psychiatrist uses a special device to deliver an electrical impulse that stimulates the brain and causes a seizure. There are no outward signs of this seizure, but the doctor can watch it on a monitor (similar to an electroencephalogram) that measures electrical activity of the brain. The mechanism of ECT action is not understood, but the seizure seems to restore the brain's ability to regulate mood.

Postpartum psychosis

About one or two mothers out of every 1,000 develop postpartum psychosis. Symptoms can appear within days of delivery and include agitation, irritability, rapidly shifting moods, disorientation, and disorganized behavior. The mother may develop delusions about the baby or hear voices (auditory hallucinations) instructing her to harm herself or the baby. Many women who develop postpartum psychosis have bipolar disorder, and some experts believe that the psychotic thinking is often a form of mania. But psychosis can also develop in women with postpartum depression.

Postpartum psychosis is a life-threatening disorder that usually requires hospitalization. Treatment usually consists of an antipsychotic medication alone or in combination with another medication, such as an antidepressant or mood stabilizer. Electroconvulsive therapy is another option.

For more information

Massachusetts General Hospital, an affiliate of Harvard Medical School, maintains an excellent Web site that is devoted to postpartum depression and other mental health conditions that affect women. The site contains commentary about recent clinical trials and offers advice about treatment options. For more information, visit the site at www.womensmentalhealth.org.

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For more references, please see www.health.harvard.edu/mentalextra.

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