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Postpartum Depression (PPD)

What is PPD?

Postpartum Depression (PPD) is an emotional disorder associated with giving birth. It is not a well-defined medical condition. There are many levels of PPD including the "baby blues," moderate depression, and postpartum psychosis.

Postpartum depression and psychosis were recognized as early as 700 B.C. by Hippocrates, who described emotional problems of postpartum women. In 1858, Marcé published a study, Traits de la Folie des Femmes Enceintes, linking negative emotional reactions with childbirth. From 1860-1967 PPD was not thought of as a unique clinical diagnosis. In 1968 the Diagnostic and Statistical Manual (DSM) II described Psychosis with Childbirth as a separated entity but in 1980 DSM III eliminated this category stating, "there is no compelling evidence that postpartum psychosis is a distinct entity."

Many women experience the "baby blues" after childbirth. It is characterized by frequent and prolonged crying, irritability, poor sleep, mood changes and a sense of vulnerability which may continue for several weeks. Women start feeling this way about 1-3 days after the birth of their babies. The "baby blues" are very common, and as many as 50-80% of women experience these symptoms after giving birth.

Depression is a more serious and debilitating condition. It is characterized by hopelessness, frequent crying, feelings of inadequacy, guilt, anxiety, irritability and fatigue. This condition is less common than the "baby blues," occurring in 3-20% of women, with a higher rate of recurrence in subsequent pregnancies. The onset may occur at any time after delivery, often after the woman had returned home from the hospital. The symptoms may last from a few weeks to several months.

Postpartum psychosis is the most severe form of PPD. It is relatively rare with symptoms of general psychotic conditions including confusion, fatigue, agitation, alterations in mood, feelings of hopelessness and shame, delusions or auditory hallucinations, hyperactivity and rapid speech or mania. Postpartum psychosis occurs in only 1 in 1000 (0.1%) births. Symptoms generally begin within the first three months.

What causes PPD?

Several theories exist regarding the cause of PPD. The most common is that hormonal levels change drastically after pregnancy, causing a shock to the woman. Estrogen and progesterone increase to ten times their normal levels during pregnancy. By three days postpartum, estrogen and progesterone drop sharply to pre-pregnant levels. One study concluded that women with the greatest drop in progesterone levels after delivery were more likely to rate themselves depressed within 10 days of delivery. Some research indicates a relationship exists between premenstrual syndrome and postpartum depression. Higher rates have been found in women with PMS as well as in those who use birth control, alcohol, and drugs. Another recent study revealed that women with obsessive-compulsive disorder (OCD) might be at an increased risk for developing postpartum depression. Severe sleep disturbance and anxiety have also been noted as possible predictors of postpartum depression. All of these studies have giving just a clue into the cause of PPD. More research is necessary to explain any biological links to the

cause of the illness.

How is PPD treated?

An important factor in preventing and treating PPD is social support. The support of a partner as well as family and friends can lessen the stress of pregnancy, delivery, and the postpartum period. One study found that only 18% of 90 mothers studied received more than 2 weeks of assistance with housework, and only 20% reported assistance with baby care beyond the first week.

Several medications are available for the treatment of PPD. Selective serotonin reuptake inhibitors (SSRIs) are the most commonly prescribed. These include Prozac (fluoxetine), Zoloft (sertraline), and Paxil (paxoxetine). The advantages of these drugs are their safety in overdose situations, and the fact that they are taken only once per day. Antidepressant therapy is also effective in lowering the rate of recurrence of postpartum depression. Other drugs are also less commonly used. For mothers considering breast-feeding, psychotropic drugs should be used with caution because most are excreted into breast milk.

Hormones are also common treatments. Progesterone and estrogen have been shown as effective treatments for PPD. Further research is needed to determine how hormones work, the best dose, and the most effective duration of treatment.

Medical professionals can not easily diagnose postpartum depression. Because hospital stays have been shortened to as little as 24 hours for deliveries, and PPD may appear anywhere from three days to one week after delivery, chances are that women will only show symptoms after they have come home from the hospital. Four-to-six-week postpartum visits, as well as the first pediatric appointment, may be the best time to assess women for depression.

Summary

Postpartum depression and psychosis are not commonly discussed in either the medical or general communities. Much research is still needed in the cause and treatments of these conditions. What is known is that many women suffer in the depths of depression but feel guilty and ashamed to present for treatment for fear they will be considered a "bad mother." As the trial of Andrea Yates unfolds in Houston the jury will be asked the question of whether or not postpartum psychosis is a mental illness. This question can only be truly answered by the psychiatric community. American culture must pave the way for women to feel empowered to ask for help and medical culture must answer with the best available treatments.

Reference:

Petricoin EF et al. Use of proteomic patterns in serum to identify ovarian cancer. *Lancet* 2002 Feb 16; 359:572-7.

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