

Postpartum Depression

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Abstract: Both maternity blues and postpartum depression are depressive states that occur after delivery. Maternity blues develops between 3 and 7 days after delivery, presenting as mild depression. The major symptoms of the blues include a depressed mood and tearfulness. In Japan, it occurs in 9% to 25% of all postpartum women. The symptoms are usually transient and disappear after about 2 weeks. Although the blues generally resolve without treatment, transformation to postpartum depression occurs in about 5% of patients. Consequently, caution must be exercised when the blues develops. Postpartum depression usually develops between 2 and 5 weeks after delivery. Like endogenous depression, it presents with a depressed mood, loss of energy, insomnia, and other symptoms. The patient may have hallucinations or suicidal ideation and may attempt suicide. The incidence of postpartum depression in Japan is 3–9%. It lasts for 3–6 months and then subsides or resolves. It is treated with the same drugs that are used for endogenous depression. It is also important to adjust the environment to make it easy for the patient to get some rest. Puerperal psychosis, relapse of schizophrenia or depression, and depressive states due to a somatic disease may also present as depression after delivery. Therefore, such depressive illnesses need to be differentiated from postpartum depression.

Key words: Maternity blues; Postpartum depression; Puerperal depression; Puerperal psychosis

Introduction

The puerperium is the period during which the mother's body, having previously undergone changes to adapt to pregnancy and delivery, returns to the non-pregnant state. This period has long been known to be associated with a high risk of psychiatric disorders. Depression

that occurs for the first time during this period is called postpartum or puerperal depression.

This article describes maternity blues and postpartum depression, both of which become manifest as depression after childbirth. Their differential diagnosis from other psychiatric disorders with clinical manifestations including a depressive state after childbirth is also

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described.

Maternity Blues

Pitt first proposed the term "maternity blues" in 1973¹⁾ to describe a mild depressive state occurring soon after delivery. The blues have attracted considerable attention because of their high incidence. This condition more frequently arises between 3 and 7 days after childbirth rather than immediately afterwards.

Maternity blues are characterized by mild depression, with the major symptoms including a slightly depressed mood and tearfulness. The latter symptom is considered particularly characteristic of the blues. The new mother becomes likely to shed tears on various occasions, for example, when relaxing after accomplishing the delivery, when she notices that none of the nurses in the obstetric ward are paying attention to her, or when her husband does not arrive in the ward on time. Some become tearful or whimper and others cry loudly.²⁾ I have witnessed a woman who cried loudly in my hospital because she was told that visiting time was over. In addition to the symptoms described above, the blues are associated with anxiety and impaired concentration. This condition is short-lived, however, and resolves after about two weeks.

The incidence of maternity blues is high. Although the definition varies among reports, the blues occur in about 12–67% of postpartum women in Western countries, while the rates reported in Japan are lower at about 9–25%.³⁾ The onset is considered to be associated with a dramatic decrease in the levels of estrogens and progesterone after childbirth. The strong association between the blues and premenstrual tension⁴⁾ also suggests an etiologic role for these hormones. There is also an association with primiparity⁴⁾ and neuroticism.⁵⁾ Neither obstetric factors, such as complications of pregnancy or the type of delivery, nor a history of psychiatric disorders is considered to be associated with the blues.⁵⁾

Because the blues are common, mild, and transient, associated with postpartum hormonal alterations, and unrelated to a woman's psychiatric history, this condition can be regarded as different from depression, being close to a physiological response.

Because the blues are mild and transient, many women recover spontaneously without any specific treatment. When depressive symptoms are severe, the patient is treated in the same way as for postpartum depression, which is described next. The blues have been reported to show progression to postpartum depression in about 5% of patients.⁶⁾ Consequently, a woman must be followed carefully when the blues become worse or persist.

Postpartum (Puerperal) Depression

The risk of depression occurring is increased at various stages of life, including the puerperium, and depression that develops during this period is called postpartum or puerperal depression. The puerperium is defined as a period of about 6 to 8 weeks after childbirth. According to the WHO definition, it is a period of 42 days. Postpartum (puerperal) depression develops usually during this period.

The onset of postpartum depression is usually later than that of maternal blues, occurring from 2 weeks after childbirth, but usually within 5 weeks. In Japan, 3% to 9% of all parous women develop postpartum depression,³⁾ a lower rate than is reported in Western countries (5% to 26%). In Japan, it is customary for pregnant women to stay at their parents' homes to prepare for delivery. Okano *et al.* suggested that the incidence of postpartum depression is lower in Japan because this custom may protect women against the development of such mental illness.⁶⁾

Like endogenous depression, the typical form of depression which is associated with changes in levels of serotonin and noradrenaline in the brain, postpartum depression involves a lowering of mood, loss of energy, and impaired work

efficiency (patients complain of inability to do housework or perform childcare, tiredness, and listlessness). Many patients complain of physical symptoms, including insomnia, decreased appetite, headache, and fatigue. When this condition is severe, the patient may even have delusions. Such patients may devalue themselves, saying "I'm unworthy to be a mother and guilty", and if their child has the slightest physical symptom, they may become possessed by the belief that the child is seriously ill. In moderate or severe depression, suicidal ideation or a suicide attempt may occur. Postpartum depression may threaten the child's life because the mother may kill her child or commit suicide after killing her child, so care must be exercised to prevent such a tragedy. Like endogenous depression, postpartum depression will usually improve or resolve after 3 to 6 months.

Serotonin and noradrenaline have been considered to play an etiologic role in postpartum depression, as is the case for endogenous depression. In addition, it has been suggested that estrogens, progesterone, and thyroid hormone are also related to the pathogenesis, but there are no consistent views about the mechanism.⁷⁾

The role of psychosocial factors in the pathogenesis is large. Childbirth and child rearing are major life events. For primiparous women, for example, childbirth results psychologically in the realization that they have to play the role of a mother while their life is being converted from a self-oriented to a child-oriented pattern, which keeps them busy and has many restrictions. After childbirth, women have to bear many psychological and physical stresses. In many reports, poor spouse support during pregnancy and after childbirth has been suggested to be one of psychosocial factors that lead to postpartum depression.^{8,9)}

Postpartum depression was reported to be associated with premenstrual tension by some authors, but not with any obstetric factors (obstetric complications, previous abortion, or stillbirth).³⁾

Like endogenous depression, postpartum

depression is usually treated with antidepressants. If anxiety is severe, anxiolytics are administered concurrently and hypnotics are used to treat insomnia. It is better to avoid breastfeeding during medication. In addition to medication, psychotherapy and environmental adjustment are important. The ability to care for children and perform housework is always impaired in patients with postpartum depression. The treating psychiatrist should not only listen to these complaints, but also give pertinent advice to reduce the burden on the patient and to have a rest. Sufficient rest is important for treating this depression. Family members, particularly the husband must be encouraged to support her. This is one of the most important points in the treatment of postpartum depression. For example, the patient can be persuaded to use a day nursery to care for the child. While her child is at the nursery in the daytime, the mother can get some rest and perform housework at her own pace. If the patient cannot rest at home or her depression is severe, hospitalization may be necessary in some cases.

Other Causes of Postpartum Depression

Some other conditions can present as a depressive state, so postpartum depression must be distinguished from such conditions.

1. Puerperal psychosis

Puerperal psychosis has a very acute onset within 2 weeks after delivery. The main symptom is confusion. The patient presents with perplexing speech and behavior as well as excitement. Hallucinations and delusions also occur in many cases. The symptoms are florid, but subside after 2–3 months. Some patients present with mild depression or emotional lability in the early phase.

2. Relapse of depression or schizophrenia

For patients with pre-existing psychiatric disease, the risk of progression or relapse is in-

Table Comparison of Maternity Blues and Postpartum Depression

| | Maternity blues | Postpartum depression |
|--------------------|---|--|
| Symptoms | Mild depressive state Depressed mood, tearfulness, etc. | Depressive state (mild to severe) Depressed mood, insomnia, suicidal ideation, loss of energy, and impaired ability to perform housework and childcare, etc. |
| Time of onset | Between 3 and 7 days after delivery | Usually between 2 and 5 weeks after delivery |
| Prognosis | Remission is achieved after about 2 weeks (Progression to postpartum depression in some cases) | Improvement or remission after 3 to 6 months |
| Incidence in Japan | 9–25% | 3–9% |

creased during the puerperium. When depression occurs in postpartum women who have had a previous episode of depression, this is not called postpartum depression, but is considered as a relapse. Schizophrenia is also likely to worsen or relapse after delivery. A depressed mood and loss of energy rather than hallucinations and delusions are prominent in some cases of schizophrenia. In a patient with mental illness after childbirth, the past history of psychiatric symptoms and treatment should always be obtained.

3. Depressive states due to a somatic disease or medication

Physical disease may present with symptoms of depression. In women after childbirth, depressive states are known to occur secondary to Sheehan syndrome and endocrine disease such as hypothyroidism. Some drugs may also cause depression as a side effect. When patients are taking drugs, depression caused by their medication should be excluded.

4. Neurosis

A diagnosis of neurosis is made in some patients in whom a mild depressive state is persistent. Problems with the personality and environmental factors are involved to a greater ex-

tent than in depression. When women who are immature and nervous face various problems after childbirth and fail to cope, neurosis can develop.

Conclusion

When a woman suffers from mental illness after delivery, she often fails to receive psychiatric assistance because it is difficult for her to visit a psychiatrist since she has to look after her baby or because her family think that difficulty in rearing a child is common to mothers. If she is left untreated and continues looking after her baby, not only the patient, but also the physical and mental growth of her child, will be affected. Therefore, early therapeutic intervention is very important.

The characteristics of maternity blues and postpartum depression, both of which present with depression after childbirth, are summarized in the Table.

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