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Postpartum Depression

Postpartum Depression is an acute illness that effects 1 out of 7 women in the United States. As defined by Jenna Carberg on portpartumdepression.org, postpartum depression “is a serious mood disorder. Women who develop PPD have feelings of intense sadness, worry and exhaustion following childbirth. PPD is extremely common.” It is important to be thoroughly educated on postpartum depression as a nurse due to the high prevalence. We must be knowledgeable in the signs and symptoms, why this phenomenon occurs, and how to educate patients during and after pregnancy. If nurses are prepared to treat patients experiencing this disease, nurses can make a true difference in the care of women across the world.

Although postpartum depression is commonly heard of, most mothers are not knowledgeable on the differences between postpartum depression, the baby blues, and postpartum psychosis. Postpartum depression effects 13% of mothers in the United States and symptoms can begin immediately and up to a year postpartum. Mothers experience sadness, severe mood swings, excessive crying, intense anger, severe anxiety, difficulty bonding with the baby, insomnia, reduced interest in activities, guilt, suicidal thoughts or harmful thoughts towards the baby. Although this is prevalent and requires treatment, there is a phenomenon that effects 50-85% of mothers called “the Baby Blues”. The baby blues occurs immediately after giving birth and lasts up to two weeks postpartum. These mothers have similar symptoms to postpartum depression but these experiences are less severe and due to a significant decrease in hormones like estrogen and progesterone. These symptoms include mood swings, sadness, irritability, crying, feeling overwhelmed, reduced concentration, anorexia, and insomnia. Note that this syndrome does not include harmful thoughts towards mother or baby. The most severe cause of postpartum depression left untreated can lead to postpartum psychosis. This syndrome effects 0.1% of mothers and symptoms occur in the first three months postpartum. These symptoms include depression, confusion, disorientation, obsessive thoughts about the baby, hallucinations, delusion, paranoia, attempts to harm self or baby. Note that this psychosis has an irregular balance of what is reality and what is not. If postpartum depression is not treated, it can lead to the worst outcome of psychosis.

The exact causation of postpartum depression is still under research but researchers do know that the dramatic shift in hormones and sleep deprivation in motherhood contributes to these symptoms. Emotional factors that happen in life like losing a job, death of a family member, and financial burdens can also contribute to the overwhelmed experiences. Risks for developing this syndrome include having a history of depression or other mood disorders, a family history of PPD, and environmental factors that increase a stressful environment.

As the nurse, you must establish a trusting and therapeutic relationship with the patient before delivery so the mothers have confidence in addressing postpartum depression if it were to occur. Listen to and observe for manifestations previously stated, ask the patient about motherhood- if negative statements are made further investigate indications of difficulty coping. If postpartum depression is suspected, provide support and educate the patient on treatment options.

Treatment regimen depends on the individual needs of the patient and the severity of the depression. Nonpharmacological treatment options for less severe cases include getting enough rest, staying hydrated, maintaining a healthy diet, avoiding alcohol, and staying physically active like walking or swimming. Attending therapy like cognitive behavioral and interpersonal can help the patient have open communication about her experiences. There are also opportunities for group therapy and support animal usage. The treatment will include medication for some patients and they would be prescribed medications such as tricyclic antidepressants, SSRIs, SNRIs, atypical antidepressants, and monoamine oxidase inhibitors. The most important way to treat these patients is to provide open communication and let them know they are not alone.

Citation

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