Postpartum Depression (PPD)

Depression is caused not only by chemical imbalances in the brain, but also by including faulty mood regulation by the brain, genetic vulnerability, stressful life events, medications, and medical problems. More specifically, PPD is caused by inconsistencies in the hippocampus. These patients are observed to have much smaller hippocampus regions than other new mothers not affected by depression. Stress is believed to decrease the neuron generation in the hippocampus, thus why their area is so much smaller. Researchers are drawing connections between low moods and slow neuron production which is backed by the fact that antidepressants take weeks, sometimes months to take effect. Many researchers are examining the cause of this effect; an increase in neurotransmitters does not immediately solve the problem, so there must be another factor in this equation. It has been tested in animal studies that the neurotransmitters lead to an accelerated rate of growth in nerve connections, which is actually what increases mood. This information opens the possibility of simply creating medications that directly target the problem and can give patients quicker results. Medications that could specifically target the growth of neurons would greatly decrease time between administering the drug to the time effects are felt by the patient. This is especially important in PPD, because new mothers are on an extremely short timeline in terms of recovery time. PPD can take an effect on the mother as well as the baby and trickle to other family members. During particularly extreme cases of PPD, the baby’s life can also be in danger as long as the mother is suffering as well.

Works Cited

Harvard Health Publishing. “What Causes Depression? - Harvard Health.” Harvard Health Blog, Harvard Health, June 2009, www.health.harvard.edu/mind-and-mood/what-causes-depression

Is Postpartum Depression Affected By Socioeconomic Status?

There was a study done on 68 women who were recruited from prenatal clinics of four Montreal hospitals. It was longitudinal to analyze the relationship between stressful life conditions and postpartum depression. They were categorized as having low socioeconomic status for Montreal living. They were given verbal questionnaires administered in the home at 30 weeks prior to giving birth, 3 weeks, 9 weeks and 6 months postpartum. The sample size was large enough to conclude valid results. The results showed that 38 percent of the mothers had a Beck Depression Inventory score of 10 or more. Without including previous depression diagnoses, chronic stress factors attributed to onset of high depressive symptomatology. This occurs specifically among first time mothers of low socio-economic status. Chronic stressors paired with inadequate social support are the most important factors associated with postpartum depression.

This experiment relates to ours by using the same data collection methods. We intended to survey the women on regular intervals, but from the hospital. The at home method could either increase reliability, or decrease the chances of the patient filling out the form. They also used a lot fewer people than we assumed would be included. They had the patients participate in a survey to determine their socio-economic status. Our design would just survey over 200 women in the entire hospital and hope that enough of them were of low status. It does confirm the validity of our hypothesis, in drawing a direct correlation and causation between low socio-economic status and postpartum depression.

https://onlinelibrary.wiley.com/doi/abs/10.1046/j.1523-536x.1999.00157.x

https://www.apa.org/monitor/2011/02/postpartum.aspx