Perinatal depression refers to depression occurring during pregnancy or after childbirth. The use of the term perinatal recognizes that depression associated with having a baby often begins during pregnancy. (Postpartum depression refers to depression experienced after childbirth.)

Perinatal depression is a serious, but treatable medical illness involving feelings of extreme sadness, indifference and/or anxiety, as well as changes in energy, sleep, and appetite. It carries risks for the mother and child. An estimated one in seven women experiences perinatal depression (Dave, et al 2010).

For most pregnant and postpartum individuals, having a baby is a very exciting, joyous, and often anxious time. But for people with perinatal depression, it can become very distressing and difficult. Pregnancy and the period after delivery can be a particularly vulnerable time. Mothers often experience biological, emotional, financial, and social changes during this time. Some individuals can be at an increased risk for developing mental health problems, particularly depression and anxiety.

Fact sheets for Persons Considering Pregnancy, Currently Pregnant, or Postpartum

- Persons with Mental Health and Substance Use Conditions Who are Planning to Become Pregnant (.pdf)
- Pregnant Persons with Mental Health and Substance Use Conditions (.pdf)
- Persons Who Develop Mental Health or Substance Use Conditions Within a Year of Giving Birth (.pdf)
- Preparing for your Medical Appointment (.pdf)

Source: APA and the CDC Foundation.

Not Just the ‘Baby Blues’

Up to 85% of all new mothers experience the “baby blues,” a short-lasting condition that does not interfere with daily activities and does not require medical attention (Johns Hopkins). Symptoms of this emotional condition may include crying for no reason, irritability, restlessness, and anxiety. These symptoms last a week or two and generally resolve on their own without treatment.

Perinatal depression is different from the “baby blues” in that it is emotionally and physically debilitating and may continue for months or more. Getting treatment is important for both the mother and the child.

In January 2016, the U.S. Prevention Services Task Force (USPSTF) updated its recommendation for depression screening in adults to include screening pregnant and postpartum women (Sui, et al 2016). In February 2019, the USPSTF recommended that clinicians provide or refer pregnant and postpartum women at increased risk of perinatal depression to counseling interventions.

An estimated 10-15% of white women experience postpartum depression and estimates for women of other racial/ethnic backgrounds are higher (Guintivano et al, 2018a; Robertson & Wells, 2023; Cannon & Nasrallah, 2019; Segre et al, 2006; Logsdon & Usui 2001). Some research has found that almost one in three Latina women experience depression during pregnancy and about one in three experience depression after childbirth (Guintivano et al, 2018b; Lara et al, 2009). Factors that may contribute to this increased risk among Hispanic women include socioeconomic status, community of residence, experiences of discrimination in health care, and immigrant status (Ceballos 2017; Crawford 2022).

Impact on Mother and Baby

Untreated perinatal depression is not only a problem for the individual’s health and quality of life but can affect the well-being of the baby who can be born prematurely, with low birth weight. Perinatal depression can cause problems with bonding with the baby and can contribute to sleeping and feeding problems for the baby. In the longer term, children of mothers with perinatal depression are at greater risk for cognitive, emotional, developmental and verbal deficits and impaired social skills (Field 2010; Brand & Brennan 2009). It is important to note that gestational carriers and surrogates are also at risk of developing peripartum depression.

Symptoms of Perinatal Depression

Symptoms of perinatal depression include (APA2022):

- Feeling sad or having a depressed mood
- Loss of interest or pleasure in activities once enjoyed
- Changes in appetite
- Trouble sleeping or sleeping too much
- Loss of energy or increased fatigue
- Increase in purposeless physical activity (e.g., inability to still still, pacing, handwringing) or slowed movements or speech [these actions must be severe enough to be observable by others]
- Feeling worthless or guilty
- Difficulty thinking, concentrating, or making decisions
- Thoughts of death or suicide

- Crying for “no reason”
- Lack of interest in the baby, not feeling bonded to the baby, or feeling very anxious about/around the baby
- Feelings of being a bad mother
- Fear of harming the baby or oneself

A person experiencing perinatal depression usually has several of these symptoms, and the symptoms and their severity may change. These symptoms may cause a postpartum person to feel isolated, guilty, or ashamed. To be diagnosed with perinatal depression, symptoms must begin during pregnancy or within one year following delivery.

Many people with perinatal depression also experience symptoms of anxiety. One study found that nearly two-thirds of people with perinatal depression also had an anxiety disorder (Fairbrother et al 2016). In 2023, the U.S. Preventive Services Task Force recommended anxiety screening for adults under 65, including pregnant and postpartum persons.

While there is no specific diagnostic test for perinatal depression, it is a clinical medical condition that is diagnosed by medical professionals. It is a real illness that should be taken seriously. Any pregnant person or new parent who experiences the symptoms of perinatal depression should seek evaluation by a medical professional — a family medicine doctor or an OB-GYN — who can make referrals to a psychiatrist or other mental health professional. Ask your doctor about their training and knowledge about perinatal mental health conditions. Although these conditions are common, not all doctors are trained in diagnosing and treating pregnant and postpartum people with mental health conditions. Your doctor can call national and state-specific consultation services to get access to specialized support. (More information: Perinatal Psychiatric Consult Line.)

Assessment should include a psychiatric evaluation and a medical evaluation to rule out physical problems that may have symptoms similar to depression (such as thyroid problems or vitamin deficiencies).

You should contact your doctor if:

- You are experiencing several of the symptoms above for more than two weeks.
- You have thoughts of suicide or thoughts of harming your child.
- Your depressed feelings are getting worse.
- You are having trouble with daily tasks or taking care of your baby.

Fathers/Co-Parents: Pregnancy/Childbirth and Depression

New fathers/co-parents can also experience symptoms of perinatal depression. Symptoms may include irritability, frustration, guilt, fatigue and changes in eating or sleeping, and any of the other perinatal depression symptoms listed above. An estimated 10% of fathers experience depression in the first year after their child’s birth (Paulson & Bazemore 2010). Some individuals are at increased risk, including younger fathers, those with a history of depression, fathers with financial difficulties, and when there are pregnancy or birth medical complications (Dave et al 2010).

Risk and Protective Factors

Any new mother/birthing individual (or gestational carrier/surrogate) can experience symptoms of perinatal depression or other mood disorders. People are at increased risk of depression during or after pregnancy if they have previously experienced (or have a family history of) depression or other psychiatric disorders, if they are experiencing particularly stressful life events in addition to the pregnancy, or if they do not have the support of family and friends.

One of the known risk factors for perinatal depression is a history of trauma or adverse life events. Latina women are more likely to have experienced adverse or traumatic events (Guintivano et al, 2018b; Howell et al, 2005).

Research suggests that rapid changes in sex and stress hormones and thyroid hormone levels during pregnancy and after delivery have a strong effect on moods and may contribute to perinatal depression. Other factors include physical changes related to pregnancy, having a child in the NICU, medical complications for mother/birthing individual or child, changes in relationships and at work, worries about parenting, and lack of sleep.

Research also suggests that, across racially/ethnically diverse populations, social support is protective against perinatal depression and that greater social support is associated with less severe perinatal depression symptoms (Pao 2019).

Treatment

Many women may suffer in silence, dismissing their struggles as a normal part of pregnancy and childbirth, and fail to seek care. Treatment for depression during pregnancy is essential. Greater awareness and understanding can lead to better outcomes for birthing individuals and their babies.

Latina mothers may place a priority on their parenting role and may hide their emotions and rely on family for needed support (Campbell 2021). When looking for help with perinatal depression, many Latinas prefer to begin by looking to family and friends before looking to formal support systems, such as a home-visiting nurse or mental health professional (Lara-Cinisomo 2014).

Like other types of depression, perinatal depression can be managed with psychotherapy (talk therapy), medication, lifestyle changes and supportive environment or a combination of these. Individuals who are pregnant or nursing should discuss the risks and benefits of medication with their doctors, as well as the risks of untreated depression. Each decision requires a careful assessment of the risk of treatment versus risk of untreated symptoms. In general, as described above, untreated depression carries risk for the mother, baby, and their relationship.

Medication

In general, with medication the increased risk of birth defects to the unborn baby is low, but each pregnancy carries a baseline risk of about 4%. Some SSRI antidepressants have been associated with a rare but serious lung problem in newborn babies (persistent pulmonary hypertension of the newborn). Psychiatric medications have also been associated with a transient, non-fatal neonatal adaptation syndrome. Long-term effects on the development of the child are limited, but, to date, data is reassuring. For postpartum, many psychiatric medications are compatible with breastfeeding.

American Psychiatric Association guidelines for treating individuals with depression who are pregnant or breastfeeding recommend psychotherapy without medication as a first-line treatment when depression or anxiety is mild. For women with moderate or severe depression or anxiety, antidepressant medication should be considered as a primary treatment (Wisner et al 2013).

Antidepressant options during pregnancy and postpartum include but are not limited to:

- Selective serotonin reuptake inhibitors (SSRIs)
- Serotonin and norepinephrine reuptake inhibitors (SNRIs)
- Bupropion (Wellbutrin)
- Tricyclic antidepressants (TCAs)

More information on pregnancy and postpartum depression and psychiatric medications:

- MotherToBaby - Organization of Teratology Information Specialists
- Breastfeeding and Psychiatric Medications - Massachusetts General Hospital, Center for Women's Mental Health
- Drugs and Lactation Database - National Institutes of Health

With proper treatment, most new mothers find relief from their symptoms. Given the high risk of relapse, people who are treated for perinatal depression should continue treatment even after they feel better and discuss with their medical providers the decision to discontinue treatment. If treatment is stopped too soon, symptoms can recur.

Self-help and Coping

The support of family and friends, joining a moms support group, and good nutrition and exercise can be helpful for those with perinatal depression. Self-help strategies for perinatal depression include resting as much as you can (sleep when your baby sleeps) and making time to go out or visit friends. Connect with support groups through Postpartum Support International, including local support groups, and online support.

How Partners, Family and Friends Can Help

Strong support from partners, family and friends is very important. Here are some suggestions from Moms' Mental Health Matters, a National Institutes for Health initiative, for how loved ones can help:

If you or someone you know needs support now, call or text 988, or chat 988lifeline.org

- Know the Signs. Learn to recognize the symptoms of depression and anxiety and if you see signs, urge her to see a health care clinician.
- Listen to Her. Let her know you want to hear her concerns. For example, "I notice you are having trouble sleeping, even when the baby sleeps. What's on your mind?"
- Give Her Support. Let her know she's not alone and you are here to help. Try offering to help with household tasks or watching the baby while she gets some rest or visits friends.
- Encourage her to seek help if needed. She may feel uncomfortable and not want to seek help. Encourage her to talk with a health care clinician. Share some information on peripartum conditions. Offer to make an appointment for her to talk with someone.

Crisis and Suicide

National Maternal Mental Health Hotline Call or text 1-833-TLC-MAMA (1-833-852-6262) Free, confidential hotline for pregnant and new moms in English and Spanish, 24/7. More information on the hotline.

Related Conditions during Pregnancy and after Childbirth

Peripartum anxiety and obsessive-compulsive disorder

Although estimates vary, a 2016 study found that about 16% of women experience an anxiety disorder during pregnancy and about 17% experience it during the postpartum period (Fairbrother 2016). After giving birth, some women develop intense anxiety, with rapid heart rate, a sense of impending doom and irrational fears and obsessions. Feeling guilty and blaming oneself when things go wrong, and worrying and feeling panicky for no good reason are signs of anxiety in the peripartum period (MGH Center for Women's Mental Health).

Treatment may include medication and therapy, alone or in combination.

Perinatal bipolar disorder

Bipolar disorder has two phases, the depression phase (the 'lows') and the manic phase (the 'highs'). When the 'lows' and 'highs' happen at the same time, it is considered a 'mixed' episode. Bipolar disorder can emerge during pregnancy or the postpartum period. Risk factors include a previous mood disorder and family history of mood disorders.

Symptoms of depression and mania:

- Severe sadness and irritability
- Elevated mood
- Rapid speech and racing thoughts
- Little or no sleep and high energy
- Impulsive decisions and poor judgment
- Delusions that can be grandiose or paranoid
- Hallucinations – seeing or hearing things that are not present

Treatment can include mood stabilizers and antipsychotic medications (Yonkers 2004) along with therapy.

Postpartum Psychosis Postpartum psychosis is a rare but serious condition — it occurs in only one or two out of every 1,000 deliveries. The symptoms of peripartum psychosis are extreme and may include insomnia, excessive energy, agitation, hearing voices, and extreme paranoia or suspiciousness. Many women with postpartum psychosis have a personal or family history of bipolar disorder. Symptoms of postpartum psychosis can be a serious medical emergency and require immediate attention.

Physician Review

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OTHER RESOURCES

More on Perinatal Depression

- American College of Obstetricians and Gynecologists - Postpartum depression
- Postpartum Support International
  - Local support groups
  - Online support
- Online PPMD Support Group (PPMD – Postpartum Mood Disorders)
- National Institutes of Health - Moms' Mental Health Matters
- Massachusetts General Hospital - Center for Women's Mental Health
- Organization of Teratology Information Specialists - Mother to Baby
- Postpartum Progress support groups
- Marcé of North America – perinatal education, advocacy and research