Postpartum blues

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INTRODUCTION

Although delivering a baby is typically a happy event, many postpartum women develop depressive symptoms [1]. These symptoms may manifest as the postpartum blues, which consist of mild depressive symptoms that are generally self-limited, but may be a risk factor for more severe syndromes of major depression.

This topic reviews the epidemiology, clinical features, diagnosis, and management of the postpartum blues. The clinical features, assessment, diagnosis, prevention, and treatment of postpartum major depression are discussed separately, as is postpartum paternal depression:

- (See "Postpartum unipolar major depression: Epidemiology, clinical features, assessment, and diagnosis".)
- (See "Postpartum unipolar depression: Prevention".)
- (See "Postpartum unipolar major depression: General principles of treatment".)
- (See "Mild to moderate postpartum unipolar major depression: Treatment".)
- (See "Severe postpartum unipolar major depression: Choosing treatment".)
- (See "Postpartum paternal depression".)

EPIDEMIOLOGY

Multiple studies suggest that the postpartum blues develop in approximately 40 percent of women within a week of delivery [2]. In a meta-analysis of 26 studies with more than 5600

postpartum women, primarily from Europe and Japan, the pooled prevalence rate of postpartum blues was 39 percent [3]. However, heterogeneity across studies was large and the prevalence ranged from 14 to 76 percent.

Risk factors — Factors that are associated with the postpartum blues include [4-10]:

- Not breastfeeding
- Stress around child care
- Psychosocial impairment
- Family history of depression
- History of:
  - Postpartum depression
  - Premenstrual mood changes
  - Oral contraceptive use that is associated with mood changes
  - Depressive syndromes predating pregnancy
  - Antepartum depressive symptoms
  - Caesarian section

PATHOGENESIS

The pathogenesis of postpartum blues is unknown. One factor may be postnatal hormonal changes that lead to abnormal neurotransmitter levels or activity:

- Estrogen levels greatly decrease in first few days after childbirth, which in turn increases the density of the enzyme monoamine oxidase-A. One study measured the total volume of distribution for the enzyme monoamine oxidase-A in healthy women who were four to six days postpartum (n = 15) and in healthy women who had not recently been postpartum (n = 15) [11]. The distribution of the enzyme in postpartum women was elevated in all seven brain areas that were studied (mean level of elevation = 43 percent). The enzyme metabolizes neurotransmitters such as dopamine, norepinephrine, and serotonin, and excessive depletion of the neurotransmitters could lead to dysphoria.

- A second study by the same group of researchers investigated the density of monoamine oxidase-A in the prefrontal and anterior cingulate cortex of healthy asymptomatic postpartum women (n = 15), and healthy postpartum women with a predisposition to crying due to sad mood (but no history of an episode of major depression; n = 12) [12]. The density of the enzyme was elevated in women who cried due to sad mood, compared with controls.

- Other studies suggest that serotonergic activity is diminished during postpartum blues [13].

Alternatively, postpartum women at risk for the maternity blues may have differential sensitivity to hormonal alterations [6].

CLINICAL FEATURES AND DIAGNOSIS

Postpartum blues (maternity blues or baby blues) refer to a transient condition characterized by several mild depressive symptoms such as sadness, crying, irritability, anxiety, insomnia, exhaustion, and decreased concentration, as well as mood lability that may include elation [14-16]. Symptoms typically develop within two to three days of delivery, peak over the next few days, and resolve within two weeks of onset [15].

Postpartum blues is common and remits spontaneously, and is conceptualized as a subclinical level of depression that is nonpathological. Nevertheless, its recognition is important because the risk of postpartum major depression (table 1) is approximately 4 to 11 times greater among women who have postpartum blues than women who do not:

- A three-month prospective study included women with postpartum blues (n = 471) during the first two weeks after delivery and women without postpartum blues (n = 382) [17]. Postpartum depression subsequently occurred in more women with postpartum blues than women without postpartum blues (3.2 versus 0.7 percent).

- A second prospective study followed postpartum women for two months and found that among those who had the postpartum blues (n = 146) or did not (n = 332), the subsequent incidence of postpartum depression was 44 and 4 percent [18].

In addition, the postpartum blues can increase the risk of subsequent postpartum anxiety disorders by a factor of four [17]. Postpartum blues may thus represent a prodrome for depressive and anxiety syndromes.

For clinicians who want to systematically screen patients for the postpartum blues, the Blues Questionnaire is a 28-item, self-report instrument that has been validated in multiple groups of women [2,19,20]. Results in one study suggested that postpartum women with relatively high scores on the scale may represent a subgroup at increased risk for unipolar major depression [21]. Nevertheless, screening is not standard practice and the scale is generally reserved for specialist services or research programs. It is not known whether screening improves outcomes,

and studies of major depression indicate that screening is beneficial only if follow-up is available to provide diagnostic interviews and treatment.

There is no standardized definition for diagnosing postpartum blues; we generally make the diagnosis if three or four depressive symptoms are present.

The World Health Organization's International Classification of Diseases – 10th Revision (ICD-10) classifies postpartum blues as postpartum depression not otherwise specified [22]. The American Psychiatric Association's Diagnostic and Statistical Manual, Fifth Edition (DSM-5) also does not recognize postpartum blues as a diagnostic entity; clinicians can use the term "adjustment disorder with depressed mood" or "unspecified depressive disorder" [23]. (See "Unipolar depression in adults: Assessment and diagnosis".)

Differential diagnosis — Depressive symptoms such as dysphoria, insomnia, fatigue, and impaired concentration can appear in both postpartum blues and postpartum major depression. However, the two disorders are distinguished in that the diagnosis of postpartum blues does not require a minimum number of symptoms, whereas major depression requires a minimum of five symptoms (table 1). In addition, the symptoms of postpartum blues are generally self-limited and resolve within two weeks of onset. By contrast, the diagnosis of major depression requires that symptoms must be present for at least two weeks. (See "Unipolar depression in adults: Assessment and diagnosis", section on 'Unipolar major depression'.)

In addition, the somatic symptoms of postpartum blues – changes in sleep and energy level – overlap with normal changes observed in postpartum women who do not have postpartum blues. Clinicians can determine whether problems with sleep and energy are due to postpartum blues or to normal puerperal-related changes by evaluating these symptoms in the context of normal expectations for the puerperium. As an example, although postpartum insomnia is common, patients who are unable to sleep even when their babies sleep may have postpartum blues.

MANAGEMENT

Postpartum blues generally resolves spontaneously and does not require treatment; patients are typically managed conservatively with watchful waiting as well as reassurance and support for the woman and her family. Adequate time for the patient to sleep and rest is essential, and recruiting someone else to care for the baby at night is often sufficient to manage insomnia. However, if insomnia persists, cognitive-behavioral therapy, pharmacotherapy, or both may be indicated. (See "Overview of the treatment of insomnia in adults".)

If symptoms of postpartum blues worsen or persist beyond two weeks, or if there is suicidal ideation, patients should be evaluated for postpartum depression and referred for indicated treatment that may include antidepressant medication and/or psychotherapy. (See "Postpartum unipolar major depression: General principles of treatment" and "Mild to moderate postpartum unipolar major depression: Treatment" and "Severe postpartum unipolar major depression: Choosing treatment".)

SOCIETY GUIDELINE LINKS

Links to society and government-sponsored guidelines from selected countries and regions around the world are provided separately. (See "Society guideline links: Depressive disorders" and "Society guideline links: Postpartum care".)

SUMMARY

- The postpartum blues develop in approximately 40 percent or more of women within a week of delivery. Factors that are associated with postpartum blues include a history of postpartum depression, premenstrual mood changes, depressive syndromes predating pregnancy, antepartum depressive symptoms, stress around child care, and family history of depression. (See 'Epidemiology' above.)

- The pathogenesis of postpartum blues is unknown. One factor may be postnatal hormonal changes that lead to abnormal neurotransmitter levels or activity. (See 'Pathogenesis' above.)

- Postpartum blues is a transient condition characterized by several mild depressive symptoms such as sadness, crying, irritability, anxiety, insomnia, exhaustion, and decreased concentration, as well as mood lability that may include elation. Symptoms typically develop within two to three days of delivery, peak over the next few days, and resolve within two weeks of onset. Although postpartum blues is common and transient, its recognition is important because the risk of postpartum major depression (table 1) is greater among women who have postpartum blues than women who do not. There is no standardized definition for diagnosing postpartum blues; we generally make the diagnosis if three or four depressive symptoms are present. (See 'Clinical features and diagnosis' above.)

- The differential diagnosis of postpartum blues includes major depression (table 1) as well as normal changes observed in postpartum women who do not have the postpartum

blues. (See 'Differential diagnosis' above.)

- Postpartum blues generally is typically managed with watchful waiting. However, patients who fail to improve within two weeks or whose symptoms worsen may require active treatment. (See 'Management' above.)

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