Mild to moderate postpartum unipolar major depression: Treatment

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INTRODUCTION

Although postpartum women are typically happy with the arrival of their babies, some women become depressed. Patients may manifest postpartum blues consisting of mild depressive symptoms that are self-limited or more severe syndromes such as unipolar major depression. Untreated postpartum major depression can result in both short- and long-term negative consequences for the mother and infant [1-4].

This topic reviews choosing a specific treatment for mild to moderate postpartum unipolar major depression. Other topics discuss treatment of severe postpartum unipolar major depression, the clinical features and diagnosis of postpartum major depression, safety of infant exposure to psychotropic drugs through breastfeeding, and the diagnosis and treatment of antepartum unipolar major depression and postpartum bipolar mood episodes.

- (See "Severe postpartum unipolar major depression: Choosing treatment".)
- (See "Postpartum unipolar major depression: Epidemiology, clinical features, assessment, and diagnosis".)
- (See "Safety of infant exposure to antidepressants and benzodiazepines through breastfeeding".)
- (See "Breastfeeding infants: Safety of exposure to antipsychotics, lithium, stimulants, and medications for substance use disorders".)

- (See "Unipolar major depression during pregnancy: Epidemiology, clinical features, assessment, and diagnosis".)
- (See "Mild to moderate episodes of antenatal unipolar major depression: Choosing treatment".)
- (See "Severe antenatal unipolar major depression: Choosing treatment".)
- (See "Bipolar disorder in postpartum women: Epidemiology, clinical features, assessment, and diagnosis".)
- (See "Bipolar disorder in postpartum women: Treatment".)

DEFINITIONS

- **Postpartum period** – We define the postpartum period as the first 12 months after birth. However, definitions of the puerperium vary. (See "Postpartum unipolar major depression: Epidemiology, clinical features, assessment, and diagnosis", section on 'Definition of postpartum period'.)

- **Postpartum blues** – During the postpartum period, many women develop postpartum blues, which are characterized by mild, transient depressive symptoms such as dysphoria, insomnia, emotional lability, and decreased concentration. Postpartum blues are not pathologic.

- **Postpartum unipolar major depression** – The diagnostic criteria for postpartum unipolar major depression are the same criteria that are used to diagnose nonpuerperal major depression (table 1). (See "Postpartum unipolar major depression: Epidemiology, clinical features, assessment, and diagnosis", section on 'Diagnosis' and "Unipolar depression in adults: Assessment and diagnosis", section on 'Unipolar major depression'.)

Severity of illness — Factors involved in choosing a treatment for postpartum unipolar major depression include the severity of illness:

- **Mild to moderate** – Mild to moderate episodes of major depression are generally characterized by five or six depressive symptoms (table 1), as indicated by a score <20 points on the Patient Health Questionnaire – Nine Item (PHQ-9) (table 2). Alternatively, a study of patients with postpartum unipolar major depression (n >4000) empirically defined relatively mild episodes as an average score of 11 on the Edinburgh Postnatal Depression Scale (figure 1A-B), and moderate episodes as an average score of 15 [5]. The PHQ-9 and the Edinburgh Postnatal Depression Scale are discussed separately. (See "Using scales to monitor symptoms and treat depression (measurement based care)", section on

'Patient Health Questionnaire - Nine Item' and "Postpartum unipolar major depression: Epidemiology, clinical features, assessment, and diagnosis", section on 'Screening'.)

Patients with mild to moderate illness generally do not manifest suicidal behavior or obvious impairment of functioning, and are less likely to develop complications such as psychotic features and/or catatonia. Mild to moderate depression can typically be managed in outpatient or partial (day) hospital settings.

- **Severe** – Severe major depression is characterized by seven to nine depressive symptoms (table 1) that occur nearly every day, as indicated by a score ≥20 points on the self-report PHQ-9 (table 2). Alternatively, a study of patients with postpartum unipolar major depression (n >4000) empirically defined relatively severe episodes as an average score of 20 on the Edinburgh Postnatal Depression Scale (figure 1A-B) [5].

  Severely ill patients often report suicidal ideation and behavior, typically demonstrate obvious impairment of functioning, and often manifest poor judgement that can place the patient and others (including children) at risk for imminent harm. In addition, patients are more likely to develop complications such as psychotic features and catatonic features and have a history of severe or recurrent episodes. Patients with severe major depression should be referred to a psychiatrist for management and often require hospitalization [6,7]. Treating major depression with psychotic features or catatonia is discussed separately. (See "Unipolar major depression with psychotic features: Acute treatment" and "Catatonia: Treatment and prognosis".)

Difficulties may arise in determining the number of depressive symptoms that are present during the puerperium because changes in appetite, energy, and sleep may be due to depression, or may represent normal postnatal-related changes. The presence of these somatic symptoms should be evaluated in the context of normal expectations for the postpartum period. As an example, postpartum patients frequently lack energy due to sleep deprivation and caring for an infant. However, lack of energy to the degree that patients need to make a significant effort to initiate or maintain usual daily activities can be a mild to moderate depressive symptom; anergia to the point that patients cannot get out of bed for hours is probably a symptom of severe depression. Uncertainty as to whether an episode of major depression is mild to moderate or severe can be resolved by referral to a psychiatrist (preferably one specializing in perinatal disorders).

GENERAL PRINCIPLES

The general principles and issues that are involved in treating postpartum unipolar major depression include:

- Setting (eg, outpatient or inpatient)
- History of prior treatment
- Educating patients and families
- Adherence
- Monitoring symptoms
- Prescribing antidepressants
- Breastfeeding
- Managing nonresponse
- Making referrals

These general principles and issues are discussed in detail separately. (See "Postpartum unipolar major depression: General principles of treatment" and "Severe postpartum unipolar major depression: Choosing treatment", section on 'Choosing treatment for breastfeeding patients'.)

CHOOSING TREATMENT

Approach to treatment — We suggest that acute treatment of postpartum patients with mild to moderate episodes of unipolar major depression proceed according to the sequence described in the subsections below. Patients start with initial therapy and progress through each step until they respond. The primary treatments are psychotherapy (eg, cognitive-behavioral therapy or interpersonal psychotherapy). However, many patients receive antidepressant medications.

Continuation treatment is generally indicated for patients who respond to acute treatment of unipolar major depression, and additional maintenance treatment is indicated for patients with an increased risk of recurrence. (See "Unipolar depression in adults: Continuation and maintenance treatment".)

Initial treatment — For mild to moderate postpartum unipolar major depression, we suggest psychotherapy as initial treatment [8-10]. This approach is consistent with multiple practice guidelines, and is especially useful for lactating patients who do not want to expose their infants to antidepressants [6,7,11-14]. However, antidepressants (eg, selective serotonin reuptake inhibitors [SSRIs], serotonin-norepinephrine reuptake inhibitors, bupropion, and mirtazapine) are a reasonable alternative if psychotherapy is not available, not successful, or is

declined, or if the patient has previously responded to antidepressants. In addition, combination treatment with pharmacotherapy plus psychotherapy is useful for some patients.

For patients with mild to moderate unipolar major depression who are breastfeeding and choose treatment with an antidepressant, there is a general consensus that the benefits of antidepressants outweigh the potential risks to the infant. The risks are regarded as low; as an example, most SSRIs pass into breast milk at a dose that is less than 10 percent of the maternal level and are generally considered compatible with breastfeeding of healthy, full-term infants [15]. Choosing an antidepressant for postpartum depression and the safety of infant exposure to antidepressants are discussed separately. (See "Severe postpartum unipolar major depression: Choosing treatment", section on 'Initial treatment' and "Safety of infant exposure to antidepressants and benzodiazepines through breastfeeding".)

When using psychotherapy to treat postpartum major depression, we typically choose either cognitive-behavioral therapy or interpersonal psychotherapy, based upon their demonstrated efficacy in multiple randomized trials in the general population of patients with major depression, as well as patients with postpartum depression [14]. However, reasonable alternatives include behavioral activation, nondirective counseling, and psychodynamic psychotherapy. Few head-to-head psychotherapy trials have been conducted in patients with postpartum depression.

The basic approach of each therapy as follows:

- **Cognitive-behavioral therapy (CBT)** combines cognitive therapy with behavioral therapy. Cognitive therapy is intended to modify dysfunctional thoughts and illness beliefs; behavioral therapy is intended to change problematic behaviors that occur in response to dysfunctional thoughts, depressive symptoms, and environmental stimuli. (See "Overview of psychotherapies", section on 'Cognitive and behavioral therapies'.)

- **Behavioral activation** is one component of CBT that is often administered on its own. The intervention aims to counteract inertia and avoidance by promoting activities and behaviors that are rewarding, decreasing avoidance behaviors and rumination, and by helping patients to improve their problem solving skills.

- **Interpersonal psychotherapy** focuses upon improving problematic interpersonal relationships or circumstances that are directly related to the current depressive episode; these interpersonal problems include role disputes (eg, marital conflicts) and role transitions (eg, becoming a mother). (See "Interpersonal Psychotherapy (IPT) for depressed adults: Indications, theoretical foundation, general concepts, and efficacy", section on 'Interpersonal problem areas'.)

- **Nondirective counseling** (also called "listening" visits) aims to help patients gain insight into and acceptance of their feelings, values, and behavior. The pace, direction, and content are determined by patients; the therapist acts as a facilitator by encouraging patients to speak, rather than providing explanations or interpretations. Nurses often administer nondirective counseling in the patient's home, whereas other psychotherapies are typically provided by doctoral level therapists in a clinic.

- **Psychodynamic psychotherapy** is intended to enhance insight into repetitive conflicts by identifying patterns of relationships, feelings, and behaviors; the patient works toward developing more productive coping styles (defense mechanisms). (See "Unipolar depression in adults: Psychodynamic psychotherapy".)

Some psychotherapies (eg, CBT, interpersonal psychotherapy, and behavioral activation), which were originally developed for the general population of patients with major depression, have been modified for use in postpartum patients, and are administered according to standardized treatment manuals [16].

Although psychotherapy is typically administered individually, some psychotherapies (eg, CBT and interpersonal psychotherapy) for postpartum depression have been successfully adapted to a group format [17-19]. Group therapy includes several useful elements, such as developing communication skills, normalizing one's problems by receiving support (eg, advice, empathy, and validation) from other patients who are experiencing similar problems, reducing social isolation and feelings of loneliness, increasing a sense of belonging and companionship, and learning through the modeling of others [20,21].

Some psychotherapies (eg, CBT or behavioral activation) can also be administered by computer (internet) to enhance accessibility, scheduling flexibility, and privacy. Multiple randomized trials have demonstrated the efficacy of web-based interventions for postnatal depressive symptoms and syndromes [22,23]. However, the rate of attrition in some studies was high.

One randomized trial found that CBT administered by telephone was also efficacious for patients with mild to moderate postnatal depression [24]. In addition, a prospective observational study found that interpersonal psychotherapy administered by nurse-midwives via telephone may be helpful [25].

Psychotherapy for unipolar major depression is typically time limited (eg, 6 to 12 sessions) [16]. Thus, patients treated with CBT or interpersonal psychotherapy generally receive a full course of therapy. Nevertheless, the optimal length of treatment is not known, and relatively short interventions may be preferable for new mothers who feel they lack the time and energy to participate in longer treatments.

Evidence of efficacy — Many of the studies that have evaluated psychotherapy for treating postpartum major depression have limitations; these include identifying cases of major depression with self-report questionnaires rather than clinical interviews, and the failure to adequately blind outcome ratings [10,16]. In addition, trials commonly lack active comparators to control for the nonspecific aspects (eg, attention) of psychotherapy, and instead use less rigorous comparators such as usual care or waiting lists.

Evidence for the efficacy of psychotherapy includes numerous randomized trials in the general population of patients with unipolar major depression. (See "Unipolar major depression in adults: Choosing initial treatment", section on 'Efficacy of psychotherapy'.)

In addition, randomized trials in patients with postnatal depression indicate that psychotherapy (eg, CBT or interpersonal psychotherapy) is efficacious [26]:

- A meta-analysis of six randomized trials compared psychotherapy (either CBT or interpersonal psychotherapy) with treatment as usual in patients with perinatal depression (n >1300; primarily postpartum depression) [11]. Remission was greater in patients who received psychotherapy than patients treated as usual (relative risk 2.1, 95% CI 1.7-2.6). The pooled analysis showed that remission with psychotherapy or usual care occurred in approximately 70 and 35 percent of patients.

- A meta-analysis of 17 trials (n >1200 postpartum patients) compared psychotherapy with control conditions (eg, usual care or waiting list) [19]. Improvement was greater with psychotherapy, and the clinical benefit was moderate to large; however, heterogeneity across studies was moderate to large.

- A meta-analysis of six trials (n >600 postnatal patients) compared psychotherapy (6 to 12 weekly sessions) with control conditions (eg, standard primary care) [27]. Improvement was more likely to occur with psychotherapy (relative risk 1.3, 95% CI 1.1-1.6).

The benefit of psychotherapy for patients with postpartum depression appears to persist beyond the end of treatment. A meta-analysis of six randomized trials (n = 516 primary care patients) compared psychotherapy with usual care at follow-up assessments that occurred a median of six months after study completion [26]. Improvement was superior among patients treated with psychotherapy, but the advantage was clinically small.

Using psychotherapy in mothers with postpartum depression can also benefit the offspring. Randomized trials have found a small to moderate positive effect upon temperament and development in the infants of mothers treated with psychotherapy (eg, CBT or interpersonal psychotherapy), compared with infants of mothers assigned to control conditions (waiting list or

usual care) [28]. The risk of abnormal child development, as well as cognitive impairment and psychopathology, in the children of mothers with postpartum depression is discussed separately. (See "Postpartum depression: Adverse consequences in mothers and their children".)

Evidence for the efficacy of specific psychotherapies for postpartum depression includes the following:

- **Cognitive-behavioral therapy** – Meta-analyses of randomized trials in the general population of patients with major depression have found that CBT is beneficial [29,30]. As an example:

  - A meta-analysis of 61 randomized trials (number of patients not reported) compared CBT with a waiting list control condition and found a significant, clinically large effect favoring CBT [31]. Other analyses comparing CBT with usual care or pill placebo found that CBT provided a clinically moderate benefit.

  - A meta-analysis of eight randomized trials (number of patients not reported) compared CBT with a control condition (eg, waiting list, usual care, or another active treatment), and found that remission occurred in twice as many patients who received CBT than the control condition (42 versus 21 percent) [32].

  In addition, meta-analyses of randomized trials have found that CBT can help patients with postpartum depression [19]:

  - A meta-analysis of five randomized trials (n = 482 patients) compared CBT (6 to 12 weekly sessions) with control conditions (eg, standard primary care), and found that improvement was more likely with CBT (relative risk 1.4, 95% CI 1.1-1.8) [27].

  - A meta-analysis of 14 studies (primarily randomized trials, sample size not reported) compared CBT with a control condition and found a significant, clinically moderate to large effect favoring CBT [33].

- **Interpersonal psychotherapy** – Randomized trials have shown that interpersonal psychotherapy is efficacious for treating the general population of patients with unipolar major depression. (See "Interpersonal Psychotherapy (IPT) for depressed adults: Indications, theoretical foundation, general concepts, and efficacy", section on 'Evidence of efficacy'.)

  In addition, randomized trials indicate interpersonal psychotherapy is efficacious for postpartum major depression [34,35]. As an example:

- A 12-week trial (n = 120 patients) compared interpersonal psychotherapy (weekly sessions) with a waiting-list control condition [36]. Recovery occurred in more patients who received active treatment than controls (32 versus 15 percent), and psychosocial functioning improved more with interpersonal psychotherapy.

- An eight-week trial (n = 50 patients) compared interpersonal psychotherapy (weekly group sessions plus two individual sessions) with treatment as usual (eg, antidepressants, psychotherapy, and/or support groups) [20]. Recovery occurred in more patients who received interpersonal psychotherapy than usual care (70 versus 33 percent), and marital functioning improved more with active treatment. In addition, the benefit of interpersonal psychotherapy persisted at the three-month follow-up.

- **Behavioral activation** – Meta-analyses of randomized trials in the general population of patients with major depression have found that behavioral activation provides a clinically large benefit [31,37]. As an example:

  - A meta-analysis of 10 randomized trials (n = 239 patients) compared behavioral activation with control conditions (eg, waiting list), and found a significant, clinically large advantage favoring behavioral activation [38].

  - A second meta-analysis included 12 randomized trials (n = 459 patients) that compared behavioral activation with control conditions (eg, waiting list or usual care), and found a significant, clinically large advantage favoring behavioral activation [39]. However, heterogeneity across studies was moderate.

  In addition, randomized trials indicate behavioral activation is efficacious for postpartum depression [40]. As an example, one trial compared behavioral activation with usual care in 83 postpartum mothers with unipolar major depression [41]. The active treatment was modified to address postnatal concerns, and consisted of 12 sessions administered through the internet, with weekly telephone support. Improvement of depression and psychosocial functioning was greater in patients who received behavioral activation.

- **Nondirective counseling** – Nondirective counseling (also called listening visits) can help improve postpartum depressive symptoms [16,21]. As an example, a meta-analysis of three randomized trials (n = 189 patients) compared nondirective counseling (6 to 10 weekly sessions) with standard primary care, and found that improvement was more likely with nondirective counseling (relative risk 1.8, 95% CI 1.1-3.1) [27]. However, heterogeneity across studies was moderate.

- **Psychodynamic psychotherapy** – Randomized trials have shown that psychodynamic psychotherapy is efficacious for treating the general population of patients with unipolar major depression. (See "Unipolar depression in adults: Psychodynamic psychotherapy", section on 'Evidence of efficacy'.)

  In addition, randomized trials suggest that psychodynamic psychotherapy is efficacious for postpartum depression:

  - One randomized trial (n = 95 patients) lasting 4.5 months compared psychodynamic psychotherapy with routine primary care and found that remission occurred in more patients who received active treatment (71 versus 40 percent) [42].

  - A randomized trial compared adjunctive sertraline with placebo in patients (n = 40) who each received psychodynamic psychotherapy (12 weekly sessions); the remission rate for all 40 patients was 58 percent [43].

Treatment-resistant patients — Patients with postnatal major depression of mild to moderate severity may not respond to initial treatment; response is typically defined as reduction of baseline symptoms ≥50 percent. Next step treatment depends upon the degree to which the initial treatment is beneficial:

- For patients who are treated with either CBT or interpersonal psychotherapy and achieve a partial response (eg, reduction of baseline symptoms 25 to 49 percent), we suggest increasing the total number of sessions (eg, providing 12 to 16 sessions rather than 8) and the frequency of treatment (eg, administering two sessions/week rather than one/week), based upon our clinical experience.

- For patients who are treated with either CBT or interpersonal psychotherapy and achieve only a minimal response (eg, improvement <25 percent), we suggest switching to the other psychotherapy, based upon our clinical experience.

However, reasonable alternatives to CBT and interpersonal psychotherapy for treatment-resistant postpartum depression include behavioral activation, nondirective counseling, psychodynamic psychotherapy, or antidepressants. In addition, we suggest that clinicians prescribe add-on treatments, depending upon availability and patient preference. (See 'Other options' below.)

Treatment-refractory patients — Patients with postpartum major depression of mild to moderate severity may not respond to sequential courses of CBT and interpersonal

psychotherapy. For these treatment-refractory patients, we suggest antidepressants. (See "Severe postpartum unipolar major depression: Choosing treatment", section on 'Overview'.)

Other options — For patients with mild to moderate postpartum depression who do not respond to initial and subsequent therapies, we suggest at least one of the following adjunctive treatments. The specific choice depends upon patient preferences and availability.

- Exercise
- Social/peer support (eg, doulas or night-nurses to protect maternal sleep)
- Parenting education
- Couples/family therapy

Adding exercise for treatment of mild to moderate postpartum depression may be helpful; exercise may represent an element of behavioral activation for patients who enjoy the activity. Evidence supporting the use of exercise includes randomized trials [44-46]:

- A meta-analysis, which included four randomized trials and one prospective observational study, compared exercise with control conditions (eg, standard care) in 221 patients with postnatal depressive symptoms [44]. All of the studies lasted 12 weeks. The analysis found that improvement was significantly greater with exercise and the clinical effect was large. However, heterogeneity across studies was also large, and thus a second analysis was performed, which included only four of the studies. Heterogeneity was no longer present, but the clinical benefit of exercise was only small to moderate and the difference between exercise and the control conditions was no longer statistically significant.

- A subsequent six-month randomized trial compared usual care (eg, antidepressants or psychotherapy) plus moderate intensity exercise (30 minutes on three to five days per week) with usual care alone; the sample consisted of patients with postpartum unipolar major depression (n = 94), including patients with suicidal ideation (34 percent) [45]. Recovery occurred in more patients who received usual care plus exercise than usual care alone (47 versus 24 percent).

The efficacy and use of exercise in the general population of patients with depression is discussed separately, as is the use of exercise in the general population of postpartum patients. (See "Unipolar major depression in adults: Choosing initial treatment", section on 'Exercise' and "Exercise during pregnancy and the postpartum period".)

Social/peer (mother to mother) support, provided either in a group setting or individually, is a psychosocial intervention that can help improve postpartum depressive symptoms. A meta-analysis of four randomized trials (n >200 patients) compared social support with control

conditions and found a significant, clinically moderate advantage favoring social support [19]. Social support may be more effective if it is provided by a peer who is or was depressed, rather than someone who has never been depressed [21].

Teaching parenting skills to mothers, an intervention that focuses upon both the mother and infant rather than solely the mother, may help reduce depressive symptoms. A six-week randomized trial (n = 54 mothers with depressive symptoms) compared parenting education with usual care [47]. The active intervention focused upon changing infant behaviors, and included four sessions teaching caregiving techniques to positively affect infant sleep, fussing, and crying. Usual care included referrals for mental health care and two sessions discussing postpartum depression symptoms. Symptomatic improvement was greater in patients who received the active intervention than usual care.

Involving the partner and other family members may help treat postpartum depression [48,49]. The administration and efficacy of couples/family therapy is discussed separately in the context of treating the general population of patients with major depression. (See "Unipolar depression in adults: Family and couples therapy".)

SAFETY OF INFANT EXPOSURE TO PSYCHOTROPIC DRUGS THROUGH BREASTFEEDING

The safety of infant exposure to psychotropic medications through breastfeeding is discussed separately. (See "Safety of infant exposure to antidepressants and benzodiazepines through breastfeeding" and "Breastfeeding infants: Safety of exposure to antipsychotics, lithium, stimulants, and medications for substance use disorders".)

ANTENATAL UNIPOLAR MAJOR DEPRESSION

Treatment of unipolar depression during pregnancy is discussed separately. (See "Severe antenatal unipolar major depression: Choosing treatment".)

POSTPARTUM BIPOLAR MAJOR DEPRESSION

Treatment of postpartum patients with bipolar major depression is discussed separately. (See "Bipolar disorder in postpartum women: Treatment", section on 'Bipolar major depression'.)

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".)

INFORMATION FOR PATIENTS

UpToDate offers two types of patient education materials, “The Basics” and “Beyond the Basics.” The Basics patient education pieces are written in plain language, at the 5th to 6th grade reading level, and they answer the four or five key questions a patient might have about a given condition. These articles are best for patients who want a general overview and who prefer short, easy-to-read materials. Beyond the Basics patient education pieces are longer, more sophisticated, and more detailed. These articles are written at the 10th to 12th grade reading level and are best for patients who want in-depth information and are comfortable with some medical jargon.

Here are the patient education articles that are relevant to this topic. We encourage you to print or email these topics to your patients. (You can also locate patient education articles on a variety of subjects by searching on “patient info” and the keyword(s) of interest.)

- Basics topics (see "Patient education: Coping with high drug prices (The Basics)" and "Patient education: Depression during and after pregnancy (The Basics)")
- Beyond the Basics topics (see "Patient education: Coping with high prescription drug prices in the United States (Beyond the Basics)")

In addition, several lay groups offer support and education to women with postpartum mood disorders and to family members. One such group is Postpartum Support International (or call 1-805-967-7636), which holds local, state, national, and international meetings. Educational information is also available at the United States Office on Women's Health.

SUMMARY AND RECOMMENDATIONS

- **Definitions** – An episode of unipolar major depression is a period lasting at least two weeks, with five or more of the following symptoms: depressed mood, loss of interest or pleasure in most or all activities, insomnia or hypersomnia, change in appetite or weight,

psychomotor retardation or agitation, low energy, poor concentration, guilt or thoughts of worthlessness, and recurrent thoughts about death or suicide (table 1).

Mild to moderate episodes of unipolar major depression are generally characterized by five or six depressive symptoms. Patients with mild to moderate illness generally do not manifest suicidal behavior or substantial impairment of functioning, are less likely to develop complications such as psychotic features, and can typically be managed in outpatient or partial hospital settings.

Severe unipolar major depression is characterized by seven to nine depressive symptoms. Severely ill patients often report suicidal ideation and behavior, typically demonstrate obvious impairment of functioning, and often manifest poor judgement that places the patient and others at risk for imminent harm. Patients with severe major depression should be referred to a psychiatrist for management and often require hospitalization. (See 'Definitions' above.)

- **General principles** – The general principles and issues involved in treating postpartum unipolar major depression include setting, history of prior treatment, educating patients and families, adherence, monitoring symptoms, prescribing antidepressants, managing nonresponse, making referrals, and breastfeeding. (See "Postpartum unipolar major depression: General principles of treatment" and "Severe postpartum unipolar major depression: Choosing treatment", section on 'Choosing treatment for breastfeeding patients'.)

- **Initial treatment** – For mild to moderate postpartum unipolar major depression, we suggest psychotherapy as initial treatment rather than other treatments (**Grade 2B**). However, antidepressants (eg, selective serotonin reuptake inhibitors, serotonin-norepinephrine reuptake inhibitors, bupropion, and mirtazapine) are a reasonable alternative if psychotherapy is not available, not successful, or is declined, or if the patient has previously responded to antidepressants. In addition, combination treatment with pharmacotherapy plus psychotherapy is useful for some patients.

  When using psychotherapy, we typically choose either cognitive-behavioral therapy (CBT) or interpersonal psychotherapy. Reasonable alternatives include behavioral activation, nondirective counseling, and psychodynamic psychotherapy. (See 'Initial treatment' above.)

- **Treatment-resistant patients** – Patients with postpartum major depression of mild to moderate severity may not respond to initial treatment with either CBT or interpersonal psychotherapy. For these treatment-resistant patients who achieve a partial response (eg,

reduction of baseline symptoms 25 to 49 percent), we suggest increasing the total number of sessions and the frequency of treatment (**Grade 2C**). For patients who are treated with either CBT or interpersonal psychotherapy and achieve only a minimal response (eg, improvement <25 percent), we suggest switching to the other psychotherapy (**Grade 2C**). (See 'Treatment-resistant patients' above.)

- **Treatment-refractory patients** – Next step treatment for postnatal major depression of mild to moderate severity that does not respond to sequential courses of psychotherapy is generally an antidepressant. (See 'Treatment-refractory patients' above.)

- **Other options** – Other options for patients with mild to moderate postpartum depression who do not respond to initial and subsequent therapies include the following adjunctive interventions: exercise, social/peer support, parenting education, and couples/family therapy. (See 'Other options' above.)

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