

Postpartum Depression

A plain-English guide for you and your family

WHAT IS HAPPENING

After you have a baby, your body goes through enormous changes all at once. During pregnancy, hormones like estrogen and progesterone climb to very high levels. Within hours after delivery, those hormones crash back down. At the same time, you are not sleeping (your baby wakes you every few hours), your daily routine is turned upside down, and you carry new worries about keeping a tiny person alive. For most new mothers, the brain's mood circuits can ride out these changes. But for about one in seven, the sudden hormone drop, the lost sleep, and the stress overload together tip the brain's emotion centers—the limbic system (the deep feeling centers) and the prefrontal cortex (the front part that steadies feelings and keeps perspective)—into a stuck low state. The brain chemicals that usually keep mood balanced—serotonin (the messenger that steadies mood and sleep), dopamine (the messenger that sparks joy and motivation), and norepinephrine (the messenger that powers energy and focus)—fall out of balance. When that happens, sadness does not lift, joy disappears, sleep stays broken even when the baby sleeps, appetite swings (too much or none at all), guilt floods in, and scary unwanted thoughts about harm—to yourself or your baby—can appear out of nowhere. These feelings are not weakness or bad parenting; they are real changes in brain chemistry that need real help. With the right treatment—talk therapy, sometimes medicine, always support and rest—the circuits can rebalance and mood can return.

What you might feel

- Feeling sad, empty, or hopeless most of the day, nearly every day
- Loss of interest or pleasure in things that used to feel good
- Extreme tiredness or no energy, even after rest
- Trouble bonding with or feeling connected to the baby
- Feeling worthless, guilty, or like a bad mother
- Trouble concentrating, remembering things, or making decisions
- Changes in appetite—eating much more or much less than usual

- Thoughts of harming yourself or the baby, or thoughts that you or the baby would be better off dead
- Hearing voices, seeing things that aren't there, or having bizarre beliefs (signs of postpartum psychosis)

Call the doctor right away if...

- Any thought of harming yourself or the baby
- Hearing voices, seeing things that are not real, or believing things that make no sense to others (possible postpartum psychosis)
- Unable to care for yourself or the baby, or feeling completely detached from the baby
- Severe anxiety or panic attacks that make it hard to function
- Rapid mood swings, confusion, or bizarre behavior that started suddenly after delivery

What the care team will do

- Ask every postpartum patient about thoughts of self-harm or harming the baby at every visit using direct questions
- Complete the Edinburgh Postnatal Depression Scale (EPDS) screening tool at the 2-week and 6-week postpartum visits and any time the mother or family expresses concern
- Assess whether the mother can safely care for herself and the baby, including feeding, diapering, and recognizing when the baby needs help
- Identify and document the mother's support system including who lives at home, who can help with baby care, and whether the family believes postpartum depression is real
- Teach the mother and family that postpartum depression is a medical illness caused by hormone changes and brain chemistry, not a character weakness or bad mothering
- Coordinate same-week mental health referral for therapy and psychiatry evaluation, and confirm the mother has transportation to get to appointments
- Review safe medication use during breastfeeding and reassure mothers that sertraline and escitalopram are compatible with breastfeeding
- Schedule follow-up contact within 48 to 72 hours after starting antidepressant medicine to check for worsening depression or new suicidal thoughts

Medicines you may be given — and why

Sertraline (Zoloft)

Sertraline blocks the pump that normally sucks serotonin (the brain messenger that steadies mood and sleep) back out of the gap between nerve cells. When serotonin stays in the gap

longer, the receiving cell gets a stronger, steadier signal. Over a few weeks, this helps lift the dark cloud of depression and makes it easier to feel joy again. Sertraline passes into breast milk in very tiny amounts — the lowest of all SSRIs — so doctors often pick it first when a mom is breastfeeding.

Escitalopram (Lexapro)

Escitalopram works the same way sertraline does — it blocks the pump that pulls serotonin back out of the gap between mood nerve cells, letting the calming, mood-lifting signal stay stronger. It is very clean and selective, meaning it targets serotonin pumps tightly and causes fewer side effects for many people. Escitalopram does pass into breast milk in slightly higher amounts than sertraline, but is still considered compatible with breastfeeding under medical supervision.

Brexanolone (Zulresso)

Brexanolone is a lab-made copy of allopregnanolone, a natural calming hormone the body makes from progesterone. During pregnancy, allopregnanolone levels soar to help keep mood steady. After delivery, they crash fast — in some women, this sudden drop overwhelms the brain's calming circuits and triggers severe depression. Brexanolone refills that calming signal by turbocharging GABA (the brain's main brake pedal), which quiets overactive fear and sadness circuits. Unlike SSRIs, brexanolone can lift depression in hours to days, not weeks.

Zuranolone (Zurzuvae)

Zuranolone works just like brexanolone — it mimics allopregnanolone, the natural calming hormone that drops sharply after childbirth. It supercharges GABA-A receptors (the brain's main calming switches), letting GABA (the brain's brake signal) work much more powerfully. This quiets the overactive fear and sadness circuits that drive postpartum depression. The major advantage of zuranolone is that it comes as a once-daily pill taken for 14 days, so you can take it at home instead of needing a 60-hour hospital IV infusion.

Where this information comes from

- ACOG Practice Bulletin No. 212: Screening and Diagnosis of Mental Health Conditions During Pregnancy and Postpartum, 2024
- American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5-TR)
- U.S. Preventive Services Task Force (USPSTF) Recommendation on Perinatal Depression, 2023
- Postpartum Support International Clinical Guidelines

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