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Postpartum Depression: A Common Yet Overlooked Condition

ReachMD Announcer:
You're listening to ReachMD. This medical industry feature, titled "Postpartum Depression: A Common Yet Overlooked Maternal Condition," is sponsored by Biogen and Supernus Pharmaceuticals. And now, here's Dr. Sarah Oreck and Dr. Brooke Kyle.

Dr. Oreck:
Hi, I'm Dr. Sarah Oreck, a board-certified reproductive psychiatrist and the co-founder and CEO of Mavida Health, a women's mental health digital platform providing care in California, New York, New Jersey, and Texas. I'm personally based in Los Angeles, and today I'm joined by my colleague, Dr. Brooke Kyle.

Dr. Kyle, could you introduce yourself?

Dr. Kyle:
Sure. Hi everyone, I'm Dr. Brooke Kyle, and I'm a board-certified obstetrician and gynecologist at Women's Care in Riverbend in Springfield, Oregon. I also help run a postpartum depression nonprofit called WellMama that provides 14 support groups weekly, a warmline for peer connection, online support, and education about perinatal mental health.

Dr. Oreck:
Together, we'll be focusing on postpartum depression, otherwise known as PPD, a common but often overlooked maternal mental health condition.[1,2] We recognize that your relationships with patients and your independent clinical judgment are essential. With this in mind, while this conversation does not provide medical advice, we'd like to share some of our own clinical experience in managing PPD.

So let's get right into it and start with a simple but revealing comparison. Dr. Kyle, do you screen your patients for gestational diabetes?

Dr. Kyle:
Yes, it's a standard part of prenatal care, and we typically screen between 24 and 28 weeks of pregnancy.[3]

Dr. Oreck:
Right, and that's because gestational diabetes affects around eight percent of pregnancies.[4] Meanwhile, PPD symptoms are reported by about 13 percent, or roughly one in eight women, after giving birth.[5]

Dr. Kyle:
So despite being one of the most common medical conditions associated with pregnancy,[1] PPD lacks the same clinical attention or regular discussion with women who are pregnant or have recently given birth.[5,6] This means women suffering from PPD go undiagnosed without appropriate screening during prenatal and postpartum visits.[2]

From your clinical experience, Dr. Oreck, what do you think contributes to PPD being overlooked?

Dr. Oreck:
Well, one of the major factors is that PPD is often labeled as just the "baby blues," which involves mild symptoms that tend to peak around five days after delivery and typically resolve within two weeks.[7,8] And given the hormonal shift that occurs after delivery, it's expected that women may experience these mood changes and feel worried, exhausted, or unhappy.[8-11]

But what distinguishes PPD from the "baby blues" is the intensity and longer duration of symptoms that are clinically significant, last at least two weeks, and result in significant distress or functional impairment.[7,8,12] While symptom onset can happen during pregnancy or

up to 12 months postpartum,[1,12] nearly half of the women diagnosed with PPD begin experiencing depressive symptoms during pregnancy.[12]

Another distinguishing factor is that PPD generally requires clinical intervention whereas the baby blues don't.[8] Without treatment, PPD symptoms can persist for a long period of time, and they can interfere with a mom's ability to care for herself and her baby.[7,8,13]

Which brings me to clinical surveillance. Dr. Kyle, who comes to mind in your practice when you think about patients who might be at risk for developing PPD?

Dr. Kyle:
Well, a history of depression is definitely a strong risk factor, but not the only one.[1,7] PPD can affect any woman,[8] and so, all patients deserve equal vigilance when it comes to screening and follow-up.

I've seen PPD develop in patients where I anticipated it—women dealing with significant life stressors, like demanding jobs, limited family support, or a history of trauma. One recent example was a patient who worked full time as a nurse anesthetist and was also a single mom, so she was managing a lot with compounding stressors. But I've also seen it in women without any clear risk factors. A mom I saw recently had a desired pregnancy and lot of support, and yet, she had difficulty bonding with her baby and eventually sank into a deep depression.

But I'll turn it back over to you now, Dr. Oreck. Beyond a patient's risk history, I'd love to hear what else you think is getting in the way of a more consistent PPD diagnosis.

Dr. Oreck:
Well, there's often a gap between what patients say and what they're truly experiencing. I think what complicates things even further is that providers may have limited time and resources, which can contribute to this gap in care.[1] And even though the DSM-5-TR criteria for diagnosing PPD are our clinical standard,[12] you may also hear patients use other terms to describe their symptoms. For example, they may say they feel "anxious" or "irritable."[7,8]

Dr. Kyle:
That's such an important point you bring up, Dr. Oreck. And just to recap for our listeners, the DSM-5-TR criteria for a major depressive episode with peripartum onset require at least five symptoms that are present nearly every day during the same two-week period. Those symptoms need to reflect a change from the patient's previous level of functioning. And peripartum onset refers to symptoms that begin during pregnancy or within four weeks after delivery.[12]

At least one of those symptoms must be a depressed mood for most of the day, or a loss of interest or pleasure in almost all activities throughout the day. Other symptoms may include:[12]

- Significant change in weight or appetite – patients may say things like, "I just never feel like eating," or conversely, "All I do is eat."
- Insomnia or hypersomnia – saying "I just lie awake watching the baby," or "All I do is sleep."
- Psychomotor agitation or slowing – "My body just doesn't want to move" or "I can't sit still."
- Fatigue or loss of energy – "I'm so tired. Where did my energy go?"
- Feelings of worthlessness or excessive guilt – "I can't do anything right. I'm not good enough to be a parent."
- Difficulty concentrating or making decisions – "I can't focus at all."
- And thoughts of death or suicidal ideation – like "Maybe this baby is better off without me. I just don't deserve to be their parent."

Now, it's important to remember that suicidal ideation, thoughts of death, and significant changes in weight or appetite do not need to occur nearly every day to count. These aren't the full diagnostic criteria for PPD, but they do form the foundation of diagnosis.[12]

Dr. Oreck:
That was a great review, Dr. Kyle, thank you. And if we put this in the context of what you talked about earlier, patients don't always articulate symptoms in clinical terms. That's why it's so important we listen closely to understand these differences and dig deeper into what our patients are saying, or even what they're not saying.

For those just tuning in, you're listening to ReachMD. I'm Dr. Sarah Oreck, and today I'm joined by Dr. Brooke Kyle for a conversation on postpartum depression. We're looking at how closing communication gaps can help improve early identification, patient engagement, and care delivery for this serious maternal mental health condition.

Now, Dr. Kyle, earlier we talked about the disconnect that can exist between how patients describe what they're feeling and how we interpret that in clinical terms. So, how do you think we can bridge that gap and strengthen patient-provider communication?

Dr. Kyle:
Great question. A big part of it is meeting our patients where they are and better aligning our clinical understanding with the language they're using. That kind of shift can potentially make a difference in how early we recognize symptoms and how effectively we support women with PPD.

Patients may use words like, "sad," "empty," or "anxious," instead of using terms like "depressed mood."[8,12] For example, one patient shared that they were overwhelmed with anxious thoughts simply when their partner left for work.

Others might describe irritability, restlessness, or a general sense of pessimism. Patients may also report physical symptoms, like pain, headaches, cramps, or digestive problems, that don't have a clear physical cause and don't respond to treatment.[8]

And then there's the emotional disconnection, like trouble bonding with baby.[8] I've had patients describe bringing their baby home and feeling no connection at all. But I've also cared for mothers who feel deeply connected to their baby and love them very much, even while experiencing PPD.

I think a big part of identifying these symptoms is helping normalize them. I often preface the conversation by saying, "Many people can feel sadness, anxiety, or other disturbing feelings after the birth of their baby. Are you having any feelings like that?"

Oftentimes, my patients talk about being unable to put their baby down, having extreme concern about leaving the baby's room, or even leaving them with a trusted provider. Just last week, a patient told me she was scared to shower because the baby might die while she was washing her hair.

So ultimately, PPD can present in many different ways, and not every woman experiences symptoms in the same way. That's why creating space for these conversations with our patients can help us recognize when there may be something more going on than the baby blues.

Dr. Oreck:
Absolutely. Now, we've talked a lot about how symptoms can be missed or misinterpreted. But even when we ask the right questions, some patients still hesitate to open up. So, Dr. Kyle, what are some of the key factors that prevent women from disclosing what they're really going through?

Dr. Kyle:
That's such an important question because there are a number of factors that can make it difficult for women to speak up openly about what they're experiencing.

One of the major barriers is the stigma around mental health issues, especially in the context of motherhood. Women may fear that they'll be judged, worry about being perceived as unfit mothers, or even fear that their baby might get taken away if they admit to struggling. This stigma often leads to feelings of shame and silence, which can prevent women from seeking help.[7,14-16]

On top of that, society sets an expectation and understanding that motherhood should be a time of joy and fulfillment. But when reality doesn't match this idealized image, it may make it even harder for women to speak up, instead of recognizing that they're not alone and what they're experiencing is a treatable condition.[7,16,17]

Early in my career, I lost a dear friend and her baby postpartum. Just days earlier, she was upbeat, put together, and had just been seen for her six-week visit. But this was before the days of routine PPD screening, and she never shared how she was really feeling. She's one of the reasons I'm here today — to help ensure women feel safe opening up, get screened, and never have to face those struggles alone.

Dr. Oreck:
I'm so sorry for your loss, Dr. Kyle, and I truly appreciate you sharing that. Your story's a powerful reminder of why awareness and screening are vital.

At the same time, I think it's also important to acknowledge the reality clinicians are working in. As I mentioned earlier, many clinicians are navigating packed schedules and limited resources, which can understandably make it challenging to have these deeper mental health conversations.[1] But I think even brief, intentional moments can start to break down those barriers.

For example, it can start with simply listening first and letting patients finish before jumping in with solutions.

- Then validate their experience. You might say, “I believe you. This is real.”
- If they’ve felt dismissed in the past, acknowledge that by saying something like, “I’m sorry you felt that you weren’t heard before.”
- You can then share why you’re recommending a particular approach.
- Make sure to use collaborative language like, “Let’s figure this out together.”
- It’s also important to respect their body knowledge, because they often know when something isn’t right.
- And make it safe for them to push back by welcoming questions and concerns.
- And finally, follow through — do what you say you’ll do. Small moments like this build trust.

As women’s health professionals, we can continue to help create safe environments where women feel comfortable talking about their mental health during motherhood.[1,18]

Dr. Kyle:
Absolutely. Now, we’re just about out of time for today, so before we wrap up, let’s take a moment for some final reflections on everything we’ve covered. Why don’t you lead us off, Dr. Oreck?

Dr. Oreck:
Sure. So first of all, I want to reemphasize how common PPD is. Symptoms are reported by about one in eight women after giving birth.[5] Yet despite that prevalence, the condition remains underdiagnosed and undertreated.[1,2] So in addition to the clinical criteria, we need to pay attention to the language our patients are using.

Early detection starts with awareness, and it requires us to listen even more intentionally than we already do. In my clinical experience, I’m always on the lookout for comments like “I just don’t feel like myself” or “I’m overwhelmed all the time.” These simple phrases may sound subtle, but they can be clinically significant and are an opportunity to dig deeper into what they are experiencing.

So those are my key takeaways, but how about you, Dr. Kyle? What final thoughts would you like to share as we close out today’s conversation?

Dr. Kyle:
I’d say one of the key takeaways for me is that screening for PPD should be routine, just like we screen for gestational diabetes, because it can affect any woman, and every patient deserves the same level of clinical vigilance.[1,3,8]

It’s also important to remember that PPD lasts longer than two weeks with clinically significant symptoms that can start during pregnancy or up to a year postpartum, and it generally requires clinical intervention.[7,8,12] If left untreated, these symptoms can persist for months, or in some cases, several years, and can interfere with a mom’s ability to care for herself and her baby.[7,8,13]

That’s why I encourage clinicians to initiate open conversations about maternal mental health with all of their patients. Stigma, shame, and the fear of being perceived as unfit mothers, or even having their babies taken away, are powerful barriers that can silence women from expressing how they’re truly feeling.[7,14-16] So we need to continue fostering environments where those conversations are normalized, and our patients feel safe and supported.

Dr. Oreck:
Well said, Dr. Kyle. And as those final thoughts bring us to the end of today’s program, I’d like to thank Dr. Brooke Kyle for joining me to share her expertise on postpartum depression. Dr. Kyle, it was wonderful speaking with you.

Dr. Kyle:
Always a pleasure. And I’d also like to thank Dr. Sarah Oreck for sharing her insights as well. Take care, everyone.

ReachMD Announcer:
If you’re thinking about suicide, call the confidential National Suicide Prevention Lifeline 24/7 at 988. If you’re having a medical emergency, call 911. If you fear for your safety or the safety of your child, get help immediately. If you are experiencing any of these or other symptoms, talk to your healthcare provider right away.

This medical industry feature was sponsored by Biogen and Supernus Pharmaceuticals, and our guests have been compensated by Biogen and Supernus Pharmaceuticals. If you missed any part of this discussion, visit Industry Features on ReachMD.com, where you can Be Part of the Knowledge.

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