

POSTPARTUM BLUES AND DEPRESSION

PPB is a transient emotional distress occurring after a "latent period" between the third and the tenth day postpartum. PPD begins during the weeks and months after delivery. It may last up to eight weeks or even longer.

Pathogenesis - Common Assumptions

I. Hormonal-Physiological Factors

A) Change in oestrogene, gestagene and prolactin balance after birth

- * Lower oestrogene level
- * Ratio of free and total estriol
- * Hypersensitivity of central D2- receptors related to effects of oestrogene
- * Lower progesterone level
- * Lower prolactin level

B) Change in cortisol and adrenaline balance

- * Higher serum-bound cortisol level
- * Level of circulating CRH
- * Lower placental steroids level
- * Reduction of circulating catecholamines
- * Lower adrenaline/noradrenaline level
- * Diminished fall in platelet alpha-2-adrenoceptor capacity

C) Thyroid dysfunction

- * Positive thyroid antibody status
- * Declination of T3

D) Change in endorphine and neurotransmitter balance

- * Beta-endorphine level
- * Decrease in platelet sub-3H-serotonine
- * Alterations of GABA-sub-(A) receptor sensitivity

2. Psychosocial-Environmental Factors

Several stress-factors influencing the mother during late pregnancy or after delivery are believed to cause PPB/PPD.

- * Delivery and pregnancy stress (e.g. caesarian section, high risk infants, previous loss of fetus)
- * Marital disharmony
- * Problems with work and/or family
- * Poor social support (e.g. lack of supportive rituals)
- * Unplanned pregnancy
- * Difficult infant temperament
- * Early separation of the mother and her infant after clinic delivery perceived as stressful event

3. Personal Factors

Some assumptions explain PPB and PPD as outcome of psychic disturbances of the individual woman in childbed.

- * Previous history of psychiatric illness
- * Poor mother-daughter-relationship
- * Paternal overprotection
- * Psychic trauma (separation etc. in childhood)
- * Poor self image
- * High level of personality-dimension "anxiety"
- * Hormonally assisted grief reaction when antenatal expectations (e.g. baby's gender) are not fulfilled

4. Adjustment Reaction

These assumptions are based on the view of depression as a maternal or parental adjustment process. Some theories point out that both mother and father may react to childbirth with depression.

5. Sociobiological Hypotheses

PPB and PPD are seen as possible preadaptations to inhibit bonding to the child so that infanticide is emotionally facilitated. One problem with this position is that infanticide, in by far most cultures, takes place immediately after birth whereas PPB sets in at day two after birth or later; PPD has even a much later onset.

Possible Consequences of Maternal Depression for the Mother-Infant-Relationship

- * Negative emotional reaction towards newborn
- * More punitive child-rearing attitude
- * Decrease of interactive skills
- * Difficulties to accept the "real" child
- * Difficulties in perceiving the infant's psychic development
- * Less continuity of rocking behaviour
- * Difficulties in breast-feeding

Puerperal depression impedes the mother-child-bond and thereby constitutes a risk factor for the psycho-social development of the child. - It is possible that Puerperal Blues has similar, but probably less severe consequences.

Conclusion

It is most unlikely that in evolutionary relevant times mothers would have been impaired in the necessary caring-behaviour towards her newborns. PPB and PPD is much lower in non-western and may be absent in traditional societies like those of the Eipo in New Guinea. Therefore, PPB and PPD could be iatrogenic/culturogenic diseases caused by our handling pregnancy, childbirth and puerperium.