A FREE GUIDE FROM POSTPARTUMDEPRESSION.ORG

The Postpartum Depression Hope Guide

For mothers, and for the people who love them

If You Need Help Right Now

You do not have to read this book first.

Call or text 988 — the Suicide & Crisis Lifeline. Free, confidential, 24 hours a day, anywhere in the United States.

Call, text or chat 1-833-TLC-MAMA (1-833-852-6262) — the National Maternal Mental Health Hotline. Free and confidential, 24 hours a day, in English and Spanish, staffed by counselors trained specifically in pregnancy and postpartum mental health.

Call 911 or go to an emergency room if you or your baby are in immediate danger, or if you are seeing or hearing things others do not, believing things others find strange, feeling confused or disconnected from reality, or have gone days without sleep.

You will not lose your baby for making the call. Calling a hotline is not a child protection report. Counselors are not assessing your fitness as a parent. The maternal hotline exists precisely because these feelings are common in new parents.

Unwanted, intrusive thoughts about harm coming to your baby are a recognized symptom of anxiety and OCD, and the distress they cause you is what tells a clinician what they are. Saying it out loud is the step that gets you help. It is not the step that gets you reported.

INTRODUCTION

Jenna's Story

Two pieces, written thirteen months apart.

Why This Book Begins Here

Everything that follows exists because of the two pieces you are about to read.

Jenna Carberg founded PostpartumDepression.org with her husband, Chris, after her own experience of it. She wrote the first of these in April of 2017, from inside the thing itself — not looking back on it, not shaped into a lesson, but in the middle, on an ordinary day, with no idea how it ended.

She wrote the second thirteen months later.

They are printed here exactly as she wrote them, in that order, because the distance between them is the whole argument of this book. Not a promise. A demonstration. One woman, the same voice, thirteen months apart.

If you have opened this at the worst part — and if you have, you know it — read the first one. It was written by someone who did not yet know she would be all right.

April 2017 — Written From Inside It

Postpartum depression is hard.

It's confusing and stressful and well depressing. I knew I first had postpartum depression when, a few days after having my baby girl I couldn't stop crying. I didn't want to take care of her; all I felt like doing was running away. Is this how everyone feels when they have a baby? Why am I having such a hard time with it? My husband immediately noticed the depression in me and took me to get help.

I've seen multiple doctors, been on multiple antidepressants from Zoloft to Paxil to Lexapro to Prozac to Viibryd. After waiting weeks and weeks for it to "kick in" nothing helped. I still felt like running away. I still wanted to cry. I still felt like, how is everyone I see enjoying their babies and every single day I'm just waiting for it to be done?

Thankfully I have an amazing support system with my husband and family. They are the only ones that are helping me get through this.

> *Just a warning, this is not a success story yet.*

I'm writing to let other moms know that if you are feeling any of these things, it's not you. It is a real disease. But I know, and believe in my heart, that this will pass. From all the moms that have had this, too, it will pass. I'm going on 8 months of this today. Believe me, every single day is a battle. Yes, there are some good days, but most days, I'm just asking and praying to be the person I was. Make me myself again.

I wasn't like this before. I was very logical. We would joke my husband is the emotional one in the relationship. I don't really know what it's like to have a pouring on of intense, scared, crying emotions. But now I do.

I'm not sure what it feels like to be a "normal" mom. That's what probably hurts the most. I'm grateful that my baby has not suffered because of my sickness. But what I hope for, is to be able to raise my beautiful daughter and enjoy her every moment. I want to have the energy to give her all this love that I feel for her. I don't want to send her to the babysitter every day because I can't make it through the day without crying.

> *This is my illness. And if you can take one thing away from all this is know, this is not you. You are a great mom. Just by caring enough to want to be a great mom.*

— Jenna Carberg, April 2017

The Truths She Kept

While she was waiting on a medication that had not yet worked, Jenna kept a list.

Not affirmations in the bright, brittle sense — not *everything happens for a reason*, not *you've got this*. Something quieter and more stubborn than that. A set of sentences she said to herself on the days when her own mind was the least reliable narrator in the room.

She published them at the end of that first post. Of everything on the site, these are what women write in about most often. They are the part people keep.

TRUTHS

- I have postpartum depression.
- What I am feeling are *symptoms* of this illness. I am not making this up.
- Bleak as life seems now, this pain will not last forever.
- I am not going crazy.
- This is a real illness, and it can be treated.
- I didn't do anything to make this happen.
- This is not my fault.
- I may have bad days, and I will have some good days. I will not always feel like this.
- I can choose to be active in the course of my recovery and help myself feel better.

AFFIRMATIONS

- I'm doing the best I can.
- This will take a long time, whether or not I try to speed it up. I must take one day at a time.

- I cannot expect too much from myself right now.
- It is okay to make mistakes.
- There will be good days and bad days.
- It is okay for me to have negative feelings. If I fight having these feelings, it might take longer to feel better.
- Even though I feel so bad, just getting through the day is proof of my strength.

Read them out loud if you can. Believing them is not required. Saying them is enough to start.

May 2018 — Written Thirteen Months Later

Let me start off by saying a few things.

First, thank God, I am free from my postpartum depression.

Second, this post is actually quite hard for me to write. I've been putting it off a bit and quite frankly, have just not wanted to think about what I went through.

Nevertheless thinking back, my postpartum depression lasted almost 9 months. The absolute hardest 9 months of my life.

I was on and off multiple prescriptions, cried almost every single day, and checked into a rehab facility basically because I had gotten to my wits end about not being able to be fixed. But that time finally came.

With the help of a very insightful psychiatrist, I was prescribed an ADHD medication called Vyvanse. I had mentioned to her that I was so tired in the day that I could barely keep my eyes open. The more energy I spent the quicker my depression came on. She put me on this medication to help my energy and the first day I took it, gone.

There was a bit more that went into it, but week after week there was continued success. The first success I ever felt. I didn't know it would ever be possible.

> *Finally, the tears went away and so much joy filled its place.*

My husband was there for me every day and sometimes I believe it was even harder on him than it was on me. He had to be my strength. And he was strong for me every day. I couldn't have made it through without him.

There are unfortunately pieces that still haunt me. When I look back at the many photos of my baby girl, sometimes it brings back the memories of all I went through and I just remember those days and weeks and never-ending moments of pain, instead of looking back and remembering all of her incredible moments. I didn't get to have the life of joy that comes with raising your little baby. That's what hurts me the most.

But I want to emphasize, this is a story of success. This is a triumph and an overcoming of darkness. My story exists to give hope and encouragement to other women just like me. Many women who are currently in the storm.

The love I have for my daughter is unlike anything I could ever describe. I always say this love is like I've discovered a new color that's never existed. When she looks at me and calls me Mama, my life is perfectly complete in that moment.

> *I am grateful to have fought this fight and won. And I am grateful for the gift of my incredible little girl that was worth it all.*

— Jenna Carberg, May 2018

What to Carry Forward, and What to Leave

Two things in Jenna's story belong to everyone who reads it. One belongs only to her.

The part that is hers alone is the medication. Vyvanse is not a treatment for postpartum depression, and it sits in this book because it is what happened to her — not because it is what will happen to you. It was prescribed for one specific problem: an exhaustion so total that it had become the engine of the depression rather than a symptom of it. A psychiatrist heard that detail, took it seriously, and followed it. Do not walk into an appointment asking for the drug. Walk in describing the thing that is actually happening to your body, the way Jenna did, and let someone trained for this follow it where it goes.

The part that belongs to everyone is that the fifth thing worked after four had not. Zoloft, Paxil, Lexapro, Prozac, Viibryd — five medications, months of waiting, nothing. Most women will not need five attempts. But if you are on your second or your third, and the quiet voice has started suggesting that you are simply the one this doesn't work on, Jenna's story is the argument for one more conversation instead of none.

And there is a third thing, easy to read past. The person who noticed first was her husband. The person who found the answer was a clinician who asked a better question. Neither of them was Jenna, at her lowest, reasoning her way out alone. That is not a failure of hers. That is simply how this illness works — it attacks the very faculty you would need to rescue yourself — and it is why so much of this book is addressed to the people standing nearby.

One more thing, and it is the sentence most recovery stories leave out. Even after the depression lifted, Jenna found that photographs of her daughter's first year brought back the pain instead of the moments. That grief — for the time the illness took, for the joy it stood in front of — is a real and ordinary part of getting well. Nobody warns you about it. Consider yourself warned, and know that it, too, softens.

Both of Jenna's posts appear in full on the site, alongside other women's accounts, at **PostpartumDepression.org**.

How to Use This Guide

This is not a book you are meant to read straight through, and you should not feel you have failed it if you don't.

It is built to be opened in the middle. Find the part that matches the question you have tonight, read four pages, and set it down. Nothing later depends on anything earlier. There is no thread to lose.

Two people are in mind on every page. One is a woman trying to work out what is happening to her, who has read a symptom list and did not recognize herself in a single line of it. The other is whoever is watching her and has no idea what to do — a husband, a partner, a mother, a sister, a friend who has started making excuses to come by more often.

Where something is written for that second reader, it is marked:

> **FOR THE PERSON READING OVER HER SHOULDER**
>
> These run throughout. They are short, and they are about what to actually do — not how to feel about it.

What this guide will not do

It will not diagnose you. No book can, and neither can a questionnaire. The screening tools at the back do something more modest and more useful than that: they turn a thing you cannot find words for into a number you can hand across a desk.

It will not tell you that everything happens for a reason, or that you are stronger than you know, or that this season is secretly a gift. Postpartum depression is an illness. It is common, it is treatable, and it is not a referendum on how much you love your child.

And it will not pretend the evidence is sturdier than it is. Where something is genuinely unknown, this book says so plainly instead of reaching for a number that merely sounds authoritative. That happens more often than you would expect, and it is deliberate. You are being handed the truth at the size it actually comes in.

About the numbers

Every figure here comes from published research, and the sources are listed at the back. Where two good studies disagree, you will get both. Where a statistic everyone repeats turns out to be a misreading, you will be told so.

Contents

PART ONE

What Is Happening to Me?

What It Actually Feels Like

Symptom lists are accurate. They are also, somehow, impossible to find yourself inside.

You read *persistent low mood, diminished interest, changes in appetite* and something in you goes quiet and says: that isn't it. That is not the shape of this thing. And so you close the page and carry on, and the days go by.

Here is what women actually say instead. See whether any of it catches.

> *"I feel like I'm watching my life through glass."*
> Detachment and unreality — extremely common, almost never on the list.

> *"I love her but I don't feel it."*
> Numbness where you had been promised a flood. This is a symptom. It is not a finding about your character.

> *"I'm fine until someone asks if I'm fine."*
> The outside holding while the inside gives way. High-functioning postpartum depression is real, and it is missed constantly, because competence reads as wellness.

> *"I'm angry all the time and I don't know who at."*
> Anger is one of the great disguises this illness wears.

> *"I keep imagining something terrible happening to him."*
> Intrusive thoughts that horrify you. Common. Not evidence that you are dangerous.

> *"They'd be better off with someone else."*
> Not a conclusion you reached. A symptom that has learned to speak in the first person, which is precisely what makes it so convincing.

> *"I can't stop scanning for what's about to go wrong."*
> Vigilance with no off switch — more often anxiety than depression, and treated differently.

> *"I miss who I was, and I feel monstrous for missing her."*
> That grief, on its own, is usually the ordinary work of becoming someone's mother rather than illness. The two travel together often enough to be confusing.

If two or three of those made you stop for a second — if you felt the small internal jolt of being described — that is worth taking seriously. Not because a book can tell you what you have. Because recognition is the thing that moves people to an appointment, and an appointment is the thing that changes the story.

How common this is

About **11.9% of mothers in the United States** report symptoms of postpartum depression. Roughly **one in eight**. Against about 3.6 million births a year, that is more than 430,000 women — every year, in this country alone.

Rates vary more than twofold by state, from about 7.2% to 17.1%. And only about **one in four** women with symptoms ever receives a diagnosis.

Sit with those two facts side by side for a moment, because together they are the whole problem. Most people get better with treatment. Most people with symptoms are never treated. The distance between those two sentences is where this illness does its damage — and it is the only part of this that anyone can actually close.

Baby Blues, or Something More

The first question nearly everyone asks is whether this is the normal thing they were warned about.

The baby blues are real, and they are mild, and they are brief. Tearfulness, worry, irritability, a bone-level exhaustion, a mood that swings from one hour to the next — that is the shape of them. You may hear them called postpartum blues or maternity blues. Same thing.

They are common, though how common depends on who is counting. The only meta-analysis, pooling 26 studies, lands on about **39%** of new mothers, with individual studies ranging from 14% all the way to 76%. You will see 80% quoted confidently in places. That is the ceiling of the range, not the middle of it.

The baby blues are not a diagnosis. They do not stop you functioning, and they lift on their own without anyone treating them.

The calendar is what tells them apart

WHEN	WHAT IS TYPICAL
Days 1–2	Often relief, exhaustion, or a rush of feeling. The mood changes have usually not begun.
Days 2–3	Tearfulness, anxiety and irritability arrive for many women.
Days 4–6	The peak, in most women, in most studies.
Up to 2 weeks	It fades on its own. Sometimes within days.
Past 2 weeks	No longer the baby blues. Time to speak to someone.

If the low mood or the fear is still with you after two weeks, or if it arrived later than those first few days rather than earlier, that is worth having looked at. Two weeks is a reason to be evaluated. It is not a diagnosis, and crossing it does not mean the worst.

There is one more test, and it is the one women tend to find most useful, because it does not require you to rate anything from one to ten. **Exhaustion lets the good moments in. Depression tends not to.** If your daughter's first real laugh landed — if it got through — that is information. If it arrived and found nobody home, that is information too.

> **FOR THE PERSON READING OVER HER SHOULDER**
>
> You will probably see this before she does, and certainly before she can say it. The marker to watch is not how sad she seems. It is whether anything still reaches her. Put a note in your calendar for two weeks after the birth. If it still looks like this then, you raise it — not her.

How Long This Lasts

There is no clean answer, and anyone who hands you a date is guessing.

What the research can give you is a shape. Most women recover. Treatment shortens it. And for a smaller group it runs a year or longer — particularly when nobody treats it.

The clearest long view comes from a study that followed 4,866 mothers for three years:

PATTERN OVER 3 YEARS	SHARE OF MOTHERS
Low symptoms throughout	74.7%
Moderate at first, then easing	12.6%
Low at first, rising over time	8.2%
High symptoms the whole way	4.5%

Said another way: about one in four mothers had elevated symptoms at some point across those three years, but only about one in twenty-two carried them the entire time. You will find the first figure misquoted online as *one in four mothers have postpartum depression for three years*. That is not what the study found, and the difference between those two sentences is somebody's hope.

The one thing worth carrying out of this chapter: **postpartum depression generally does not lift on its own.** Waiting is not a neutral act. It is a decision, and it has a cost.

It can begin later than anyone tells you

Late onset is well documented. In one Australian study following women across a year, more than a third of cases began after the first two months. A smaller American study found a second wave of new cases around eighteen months after birth.

And it often begins before the birth at all. About **six in ten** depressive episodes found in the weeks after delivery actually started earlier — roughly a third during pregnancy, a quarter before it. Far from discouraging, that is among the most useful facts in this book. A thing that can be anticipated can be watched for. And a thing that is watched for is usually caught early.

PART TWO

What This Might Be

These are not degrees of one illness. They are distinct conditions that keep close company, and they are treated differently — which is the entire reason it is worth knowing which one has hold of you.

Postpartum Depression

The name is misleading, and the misleading has consequences.

"Depression" promises sadness, and for a great many women sadness is not the main event. Numbness is. Or fury. Or a flat, grey competence in which you do every single thing correctly and feel nothing at all while doing it — bottles washed, laundry folded, a house running like a machine with no one inside it.

It is an illness. It reaches about one in eight women who give birth in this country. It responds to treatment. And it does not confine itself to mothers — fathers, adoptive parents, and partners in same-sex relationships get it too.

What clinicians are actually looking for

- Low mood, or the loss of interest and pleasure, most of the day, nearly every day
- Present for at least two weeks
- A change from how you were before
- Getting in the way of ordinary life

Around those: sleep that is disturbed beyond what the baby accounts for, appetite gone strange, concentration in pieces, a sense of worthlessness or a guilt out of all proportion, and thoughts of death or of harming yourself.

That last one deserves its own line, and its own paragraph, and your attention. The thought that your family would be better off without you is a *symptom of the illness*. It is not a conclusion you arrived at through careful reasoning, however much it presents itself that way. It

is also the symptom women are least willing to say out loud — which is exactly, precisely backward, because it is the one that most needs saying.

Why it happens

There is no single cause, and anyone offering you one is selling something. What is true is that several things stack: a hormonal cliff in the days after delivery, sleep stripped to nothing, a personal or family history of depression, a birth that went hard or went frightening, feeding that will not work, money, thin support, and the sheer seismic scale of becoming someone's mother.

Having had postpartum depression before makes another episode substantially more likely — in one Danish national study, many times more likely. Tell your care team that before the next baby arrives. It changes what they watch for, and being watched for is a kind of safety.

Postpartum Anxiety

Some worry after a baby is simply the tax of loving something this much. The question was never whether you are worried.

Of course you are worried. The question is whether the worry has stopped protecting your child and started costing you.

Postpartum anxiety gets missed for a structural reason: routine screening after birth is built around depression. So a woman who is not sad but frightened — vigilant, wired, unable to put the baby down or unable to pick her up — hands in her questionnaire and is told the score looks fine.

What it looks like

- Worry that will not switch off, and that leaps from subject to subject
- The body joining in — racing heart, tight chest, nausea, dizziness, breath that will not come
- Checking. Then checking again. Breathing, temperature, the monitor, the locks
- Lying awake while the baby sleeps, scanning the dark for the thing that is coming
- Not being able to hand the baby to anyone, including the person who made her with you
- Turning down visitors, or dreading the ones you didn't

Estimates vary, because it is so under-recognized. Roughly 15% of women have significant anxiety symptoms in the first six months, and about one in ten meet the criteria for an anxiety disorder outright.

Anxiety or depression?

They overlap so thoroughly that separating them can feel like splitting hairs, and plenty of women have both. Broadly: depression pulls downward into flatness and loss of interest. Anxiety pulls tight — fear, arousal, a body braced for impact.

The distinction matters because it changes what you ask for. *"I am not sad. I am frightened all the time."* Say that sentence in an appointment and watch what happens to it. It is frequently the thing that turns a routine visit into actual help.

It can start in pregnancy, in the first weeks, or late in the first year and beyond. There is no window after which it stops counting.

Intrusive Thoughts and Postpartum OCD

This is the chapter women turn to alone, read twice, and tell no one about.

Unwanted, intrusive thoughts of something terrible happening to the baby are extraordinarily common in new parents. They arrive without invitation. They are vivid in a way ordinary worry is not. And they are horrifying precisely, exactly, *because* they run against everything you want in the world.

> **If you read one paragraph in this book, read this one.** The American College of Obstetricians and Gynecologists states that most women who find these thoughts distressing "will not act on them; as such, there is low risk of infant harm."
>
> In a study of 388 new mothers, women who had unwanted thoughts of intentionally harming their baby were **no more likely** to behave aggressively toward that baby than women who never had such a thought at all. The same held for women with postpartum OCD.

The clinical word is *ego-dystonic* — meaning the thought is foreign to you, unwanted by you, at war with you. And here is the thing worth understanding: the horror you feel is not a sign of danger. It is the diagnostic feature. It is the very thing that tells a clinician what they are looking at.

In one study following women across the first postpartum year, nearly all reported unwanted thoughts of accidental harm, and about half reported thoughts of intentional harm. They were at their worst in

roughly the first eight weeks and, for most women, grew quieter or vanished by six months.

When it becomes OCD

Postpartum OCD is what happens when the thoughts start driving the car — checking, avoiding, seeking reassurance, running mental reviews. The compulsion brings relief for a few minutes, and then the thought returns a little louder, having learned that it works. That is the loop, and it is why willpower alone rarely breaks it.

It reaches a small but real share of new mothers. The treatment with the strongest evidence behind it is exposure and response prevention, which asks you to face the feared thought *without* performing the ritual that usually follows — so that the fear, starved of its reward, fades on its own. An SSRI often runs alongside it.

Telling a clinician about an intrusive thought is not dangerous, and it is not a confession of intent. The people who work with new parents expect to hear these. You will not be the first one this week.

> **FOR THE PERSON READING OVER HER SHOULDER**
>
> If she tells you one of these, what you do in the next ten seconds matters more than anything else in this book. Do not flinch. Do not go quiet. Do not ask whether she would ever really do it. Say that you are glad she told you, that you know she wouldn't, and that it sounds exhausting to carry that around. Then help her book the appointment. Her telling you is not the alarm. It is the system working.

Postpartum Rage

If you have screamed at your husband over a dishwasher, thrown something and heard it break, or felt a hot surge of fury at a crying infant and then sat on the bathroom floor terrified of yourself — you are not the first woman to do that, and you are not the hundredth.

Postpartum rage is anger out of all proportion, arriving in the weeks and months after a baby. It comes fast, usually over something small enough to be embarrassing, and it leaves shame behind it like a tide going out.

It is not a separate diagnosis. It is a presentation — most often of postpartum depression or anxiety, both of which list irritability and anger among their symptoms, and both of which are routinely hunted for as sadness instead.

An honest word about the numbers

Nobody knows how common it is, because nobody counts it separately.

You will find "one in four mothers experience postpartum rage" repeated across the internet with great confidence. It is a misreading — the figure refers to postpartum mental health conditions overall. We would rather tell you the data does not exist than hand you a number that sounds authoritative and isn't.

In the moment

A crying baby in a crib is safe. Leaving the room is not abandonment — it is the responsible act, and it is the right one. If you can feel it rising, put her down somewhere safe and walk away for two minutes. That is

not a failure of patience. That is a mother managing an illness correctly.

Afterward, the shame usually hurts worse than the anger did. That shame is exactly what keeps women from mentioning any of this at their appointments — which is how rage goes untreated, and how the depression sitting underneath it goes unfound.

Birth Trauma and Postpartum PTSD

A birth can be traumatic even when the chart says everything went fine.

What is on the chart is not what is in your body. Feeling powerless, unheard, frightened for your life or your child's, or handled without your consent can all produce a trauma response — whether or not a single thing went medically wrong.

The largest meta-analysis to date, pooling 154 studies, puts postpartum PTSD at about **4.7%** overall, and substantially higher among women who experienced their birth as traumatic.

What it looks like

- Flashbacks, or memories of the birth that arrive uninvited and in full color
- Nightmares
- Avoiding the reminders — the hospital, the road to it, the conversation about it
- A body that never quite stands down
- Numbness, or a strange distance from the baby
- Reacting hard to medical appointments

It is regularly mistaken for postpartum depression, and it answers to different treatment — trauma-focused therapy and EMDR have the strongest evidence. Ask specifically for someone trauma-informed. The word matters; use it.

Postpartum Psychosis, and What the News Gets Wrong

Every few years a case reaches the news, and it is always the same story, told the same way. That story is real. It is also the single least representative thing that could possibly have been chosen to stand for this illness.

Postpartum psychosis is a psychiatric emergency in which a new mother loses contact with reality in the days or weeks after birth — delusions, hallucinations, deep confusion, or an inability to sleep that runs on for days. It reaches roughly **1 to 2 in every 1,000 births**. It arrives fast. It is treatable. And with prompt care, most women recover completely.

The common version is not the dramatic one

In a cohort of 130 women admitted for postpartum psychosis, researchers found three distinct profiles: **depressive (41%)**, **manic (34%)** and **atypical (25%)**.

The most common presentation is the one that looks *least* like the headline. And because it looks least like the headline, it is the one that gets missed — in that same cohort, the women with the depressive profile began treatment about two weeks later than the others. Two weeks, lost to a picture the culture has in its head.

The number behind the headlines is disputed

You will see it stated that around 4% of postpartum psychosis cases end in infanticide. That figure is contested in the peer-reviewed literature. A 2017 review traced it back to a misreading of one Scottish

follow-up study of 82 patients — most of whom had depression rather than psychosis at all.

Compiling roughly 4,000 documented cases from the historical record, the same author found filicide in about 1.2% overall: 4.5% among the depressive presentations, and under 1% among episodes without overt depression. His own conclusion was that the risk "has also been exaggerated."

And thoughts are not acts. Among those 130 hospitalized women, 19% had thoughts of suicide and 8% had thoughts of harming the infant — which means 92% did not report such a thought at all.

Four things to hold onto

- Most women who develop postpartum psychosis have **no prior mental health diagnosis**. Its absence is not protection, and its presence is not a sentence.
- It is not something you can have quietly. It involves visible change — confusion, days without sleep, believing what is not true — and the people around you will see it.
- **Insight is usually lost.** People in psychosis characteristically do not know anything is wrong. Which means that carefully examining whether you might have it is, in itself, a reassuring sign.
- **Postpartum depression does not turn into psychosis.** They are different conditions, with different onsets. You are not standing at the top of a slope.

It answers to treatment, and no one reports that part

In a specialist unit treating 64 women with first-onset postpartum psychosis under a structured protocol, **98.4% reached complete remission.** None required electroconvulsive therapy. At nine months, 79.7% were still well.

That is a best case rather than an average — one expert center, one protocol, first episodes. But it is the correct counterweight to a news archive assembled entirely from the worst nights of other people's lives.

> **FOR THE PERSON READING OVER HER SHOULDER**
>
> This is the one where you act tonight, not Thursday. If she is not sleeping at all, seems confused, is saying things that do not track, or believes something that is not true — call 911 or take her to an emergency room. Do not wait until you are certain. You will not be in trouble for being wrong, and being wrong costs you one evening.

PART THREE

What Helps

Everything in this part is something that has been shown to work, and something you can actually ask for by name.

What Treatment Actually Involves

The sentence that gets you seen fastest is the plainest one you own.

"I gave birth eight weeks ago and I think I have postpartum depression. I would like to be screened today."

Say it in that order. No preamble, no apology, no softening it into a question about whether you might possibly be overreacting. You are not required to make your own case before you are allowed to be helped.

And you do not need a specialist to begin. For most women the fastest door is the clinician they already have.

- **Your ob-gyn, midwife or primary care doctor** can screen you, start medication, refer you to therapy, or all three.
- **Your baby's pediatrician** is a legitimate door. Pediatric practices screen parents too, and nobody will find the question strange.
- **A therapist** — psychologist, clinical social worker, licensed counselor, marriage and family therapist — provides the talk therapy that is first-line treatment for mild to moderate postpartum depression.
- **A psychiatrist or psychiatric nurse practitioner** handles medication, and becomes important when depression is severe, has not answered to a first attempt, or arrives with company.

For moderate to severe depression, the recommendation is both — therapy and medication together. For milder symptoms, therapy alone is often the first move, and it is entirely reasonable to say you would like to try that first. You are allowed preferences. This is a collaboration, not a sentencing.

What the timeline honestly looks like

- Some benefit from medication can show up within a week, but meaningful change usually takes **four to eight weeks**.
- The first one to two weeks on an SSRI are frequently the worst of it — nausea, jitteriness, sleep made stranger — and that is precisely when most people quit. Those effects generally settle. Knowing that in advance is half of surviving it.
- Once you reach a dose that works, staying on it **six to twelve months** is what is recommended to keep it from returning.
- The same questionnaire gets used again to track you. An improvement of 50% or more counts as a treatment response.

And if you are already on medication and become pregnant: do not stop on your own. Stopping during pregnancy or postpartum carries a high risk of the illness coming back. Have the conversation first.

Therapy

Knowing which therapy you want is the easy half. The hard half is finding a human being who does it, takes your insurance, and can see you before the season changes.

The two with the strongest evidence

Cognitive behavioral therapy works the seam between thought, feeling and action — catching the patterns that hold the low mood in place, and changing what you do when they show up.

Interpersonal therapy works on relationships and role transitions, which makes it almost custom-built for this particular upheaval. It was designed for exactly the kind of earthquake a new baby sets off.

Both have good evidence in perinatal populations, and neither is clearly better than the other for most women. Which means the practical answer is simple and slightly unglamorous: whichever one you can actually get to.

How to find someone, short version

1. **Look for three letters: PMH-C.** Perinatal Mental Health Certification. It means this person trained specifically for the thing you have.
2. **Check insurance on the phone, not in a directory.** Online provider lists are frequently, almost comically out of date. Call the number on your card and read them the names.
3. **Ask when the next genuinely available appointment is** — not the next opening in principle.
4. **Take the first real opening rather than holding out for the perfect match.** You can change therapists later. Waiting eight

weeks for one particular name is the thing that most often goes wrong.

If the one you want is out of network

Ask whether they will give you an itemized receipt after each session. Many plans reimburse a portion of out-of-network care when you submit one yourself.

Then ask your insurer about a *single case agreement* — where a plan agrees to cover an out-of-network provider at in-network rates, because no in-network provider is genuinely available. It is not advertised. It is sometimes granted. And almost nobody asks, which is the only reason worth telling you about it.

Groups are not the consolation prize

A support group is not a substitute for treatment. But it is free, it is nearly everywhere, and it does one thing individual therapy structurally cannot: it puts you in a room with women who are not surprised by anything you say.

For many women that is the moment the isolation breaks — not being advised, not being assessed, simply being unremarkable in a room for an hour.

Medication

There is one medication approved specifically for postpartum depression, and several more used well for it.

Antidepressants

SSRIs are what most women are offered first. In postpartum trials, about 55% improved on an SSRI against 43% on placebo — real, meaningful, and not a miracle. The studies were small. You deserve both halves of that sentence.

Sertraline and escitalopram are common first choices, and sertraline in particular carries extensive, reassuring safety research in this population.

What these drugs do is change how brain chemicals such as serotonin behave. Exactly why that lifts depression is still not fully understood, and anyone who explains it to you with complete confidence is simplifying something the field has not finished.

Zuranolone

Zuranolone — brand name Zurzuvae — is the first pill approved specifically for postpartum depression. It is taken once daily for fourteen days rather than indefinitely, and it works quickly: days, not weeks.

Worth knowing: it causes drowsiness, and there is a twelve-hour driving restriction after each dose. It is a controlled substance. And almost nobody pays the list price — there is a manufacturer support program and a specialty pharmacy route, which is the entire difference between reading about a drug and actually having it in your hand.

Brexanolone

Brexanolone — Zulresso — was the first drug approved specifically for this illness. It is given as a sixty-hour intravenous infusion in a certified setting, and it works rapidly. The logistics are the problem: three days, monitored, usually apart from your baby. It is used far less now that an oral option exists.

If brexanolone is what brought you back, that experience was real and it counts.

A word about benzodiazepines

Medications like lorazepam are sometimes used as a short bridge for severe anxiety while an antidepressant gets to work — typically two to four weeks, then a gradual taper. ACOG advises using them sparingly because of the risk of dependence, prefers lorazepam, oxazepam or temazepam, and specifically advises against alprazolam.

They are not a treatment for OCD. And they should never be stopped abruptly.

Feeding, Medication and Sleep

You do not have to choose between treatment and breastfeeding. Let that sentence land before you read another word.

ACOG advises against stopping mental health medication for breastfeeding alone. Sertraline passes into milk in very small amounts — around 0.5% of the weight-adjusted maternal dose — and in one pooled study, most infants' blood levels were too low to detect at all.

The specific drug matters, so bring the actual name to your prescriber rather than the general question. What helps nobody is the third option women quietly choose: not filling the prescription and saying nothing.

The closeness, and the difficulty

Both are true at once, and almost everything written about this picks one and pretends the other isn't there.

Feeding can be the part of the day that goes right — the one reliable hour, skin and quiet and something working. It can also be the thing that hurts, takes an hour, happens eight times a night, and that you begin to dread around four in the afternoon. If you have postpartum depression, it is frequently both, in the same day, four hours apart.

The relationship runs in both directions. Depression makes breastfeeding harder. Difficulty with breastfeeding makes depression more likely. Neither has been shown to cause the other, and you are not obliged to work out which came first.

The finding that matters most

Researchers using a large British longitudinal study did something clever: they compared women by what they had *planned* to do, as well as by what they did.

The lowest risk of postpartum depression was among women who planned to breastfeed and did. **The highest risk of all was among women who planned to breastfeed and then could not.**

Read that twice, because it is not the message you have been given. The problem is not formula. The problem is the gap between what you intended and what happened.

Which means a woman who chose formula from the beginning and a woman who wanted to nurse and couldn't are in genuinely different situations, even as they feed their babies identically. The second one has lost something real. That loss deserves to be named rather than managed away with reassurance that the method doesn't matter.

Sleep is the lever, and it is not the bottle

The standard advice is that a partner gives a bottle so the mother can sleep. The evidence says something more precise: the sleep comes from not being woken, not from what is in the bottle.

A study following 155 women across the first two postpartum years found that neither breastfeeding itself nor the proportion of breast milk in the baby's diet was significantly associated with the mother's sleep. What predicted it was the number of night feeds — each additional waking cost roughly 6.6 to 8.4 minutes of sleep, regardless of what the baby was fed.

So a partner who prepares a bottle while she still surfaces has bought her very little. A partner who takes an *entire waking* — gets up, feeds, settles, returns, while she stays under — is the version the evidence

actually points at.

Two honest caveats. No trial has tested partner night feeds for their effect on maternal mood. And an older, smaller study found breastfeeding mothers slept somewhat longer than formula-feeding ones. What does have trial evidence behind it is treating the insomnia directly: cognitive behavioral therapy for insomnia, delivered in pregnancy, improved postpartum depressive symptoms at six months.

FOR THE PERSON READING OVER HER SHOULDER

This is the most concrete thing in this book that you can do, and you can start tonight. Pick one night waking and own it entirely — you get up, you feed, you settle, she does not surface. Not "wake me if you need me." The whole waking, every night, without her having to ask. If she is breastfeeding, that means one bottle of expressed milk or formula for that feed. One unbroken stretch of sleep is not a kindness. It is treatment.

Paying for It

Cost is the reason a great many women never make the first appointment. And the guesswork is almost always worse than the reality.

For women paying entirely out of pocket, a 2024 national study found an average cash-pay psychotherapy rate of about **$147 per session**, varying by state. Hold two things about that number: it is the *self-pay* rate, not what someone with insurance pays, and a copay is typically far lower.

If you have Medicaid

This changed recently, and a great many women have not heard.

Medicaid used to end sixty days after birth — a cliff edge arriving exactly when postpartum depression tends to peak. **All fifty states and the District of Columbia have now extended postpartum coverage to twelve months.**

What is uniform is how long you remain eligible, not everything covered within it. But if someone told you at your six-week visit that your coverage was about to run out, that information may simply be out of date. It is worth a phone call.

What parity law does, and what it does not

When a plan covers mental health treatment, the limits on that care — copays, coinsurance, visit caps — cannot be stricter than the limits the same plan puts on medical and surgical care.

What it does not do, in the federal government's own words, is **require plans to provide mental health benefits at all**. Parity is a rule about fairness between categories. It is not a guarantee of

coverage. Marketplace plans under the Affordable Care Act do have to cover mental health, as an essential health benefit.

Routes that cost less, or nothing

- **Sliding-scale fees.** Many clinicians set fees by income. Ask when you call. It is an ordinary question and it costs you nothing to say.
- **Federally qualified health centers** see patients regardless of ability to pay, on a sliding scale.
- **Your employer's EAP.** Employee assistance programs usually offer short-term counseling at no cost to you.
- **The National Maternal Mental Health Hotline** — free, and staffed by people trained in precisely this.
- **Support groups and warmlines** — free, and built for the evenings that are not emergencies but should not be spent alone with your own head.

If a claim is denied

A denial is not the end of anything. You have the right to an internal appeal, and if that fails, to an external review by an independent third party — which is to say the insurance company stops being the final word on your care.

And denials are frequently administrative rather than substantive: a coding error, a missing referral, a provider listed as out-of-network who isn't. Ask what specifically was denied before you accept that the answer is no.

PART FOUR

For Partners, and for Anyone Watching

This part is written to you directly. You are usually the one who notices first, and almost always the one with the least idea what to do about it.

What You Are Seeing

Her pulling away from you is a symptom. It is not a verdict on you.

Postpartum depression causes withdrawal, and withdrawal lands hardest on whoever is standing closest. Which means you can find yourself feeling shut out, rejected, and quietly resentful — while simultaneously feeling that you have no right to any of it, because she is the one who is ill.

Both things can be true. You are allowed to find this hard. Finding it hard does not make you a bad partner, and it does not mean you are failing her.

What to watch for

- Nothing reaching her — not the baby's first real laugh, not the things she used to love
- "I'm fine," delivered flat, on repeat, to everyone who asks
- Anger arriving fast and out of proportion, with shame close behind it
- Not sleeping, even when the baby finally does
- Checking constantly — or the opposite, a reluctance to be alone with the baby at all
- Anything at all about the baby being better off without her

Put a note in your calendar for two weeks after the birth. If it still looks like this then, the two weeks have told you what you needed to know.

What to Say

Every guide tells you to communicate. Almost none of them tell you what to actually say. Here are words you can borrow.

When you want to raise it for the first time

> *"I'm not going to bring this up again after tonight, so I want to say it properly. You haven't been yourself since March, and I don't think it's tiredness. I made an appointment for Thursday at two. I'll drive, and I'll sit in the waiting room or come in — whichever you want. If you'd rather I cancel it, I'll cancel it. But I can't keep watching this and doing nothing."*

When she says she's fine and she isn't

> *"Okay. I'm not going to argue with you about it. I just want you to know I've noticed, and I'm not going anywhere, and you can change your mind about talking any time."*

At three in the morning

> *"You don't have to talk. I'm going to sit here."*

When she tells you something frightening

> *"I'm glad you told me. I know you wouldn't. That sounds exhausting to be carrying around."*

Then help her make the appointment. Do not ask whether she would really do it. Do not go silent and think about it. The ten seconds after she says it out loud will decide whether she ever says anything like it to you again — and she will be watching your face the entire time.

What not to say

- "But you have so much to be happy about."
- "Have you tried getting out of the house?"
- "My mother had four and she was fine."
- "You look great!" — to a woman who feels like a stranger in her own body
- Anything at all that begins with "at least."

When she will not get help

This is the situation nearly every guide skips, and it is the one you are most likely to be in.

Do not deliver an ultimatum. Do not turn it into a test of whether she loves you or the baby enough to go. Make it small, concrete, and easy to say yes to: book the appointment yourself, offer to drive, offer to make the phone call — and give her a real exit.

"I made the appointment. You can cancel it" will work far more often than "you need to see someone." One of those hands her a decision. The other hands her a task, at the precise moment she has nothing left for tasks.

And if she refuses and you are genuinely frightened, you do not need her permission to pick up the phone. Both 988 and the maternal hotline will talk to *you*.

You Are at Risk Too

About one in ten new fathers develops depression. When the mother is depressed, the rate among partners climbs considerably higher.

It wears a different face. In men it shows up more often as irritability, as anger, as working later than the work requires, as drinking a little more than usual, as retreating into a screen, as physical complaints with no clear cause — or as a grim, uncomplaining competence that never once puts itself down. Long hours can feel like providing. Sometimes they are just somewhere else to be.

You are the person most likely to be struggling right next to her, and the least likely to be asked about it by anyone.

The standard screening questionnaire was built for mothers, and appears to need a lower threshold to catch depression in men — one reason paternal depression is missed so consistently. If any of this is landing, say so to your own doctor. Not hers. Yours.

Two depressed parents is harder on a baby than one, and that is not written here to frighten you. It is written because getting yourself treated is not a distraction from taking care of her. It is part of it.

When It Is Tonight

Most of this book concerns things that can wait until Thursday. This chapter does not.

Act tonight — call 911, or go to an emergency room — if she is:

- Seeing or hearing things that are not there
- Believing things that are not true, or that others find strange
- Confused, or disconnected from reality
- Not sleeping at all, for days
- Talking about dying, or about the baby being better off without her
- Behaving in a way you cannot explain and have never seen before

Those can indicate postpartum psychosis, which is a medical emergency — and which responds extremely well to treatment when it is caught quickly.

You will not get in trouble for being wrong. Being wrong costs you one evening. Being right and waiting can cost far more than that.

988 — Suicide & Crisis Lifeline. Call or text. Free, 24 hours.

1-833-852-6262 — National Maternal Mental Health Hotline. Call, text or chat. English and Spanish.

911 — immediate danger.

PART FIVE

Checking In

Two questionnaires, reproduced in full, and what the numbers actually mean.

How to Use These

A score is not a diagnosis. It is a translation.

It takes something you cannot find words for and turns it into a number you can carry into a room and set on a desk. That is a smaller thing than a diagnosis and a far more useful one than nothing, which is what most women bring.

Two questionnaires follow. The PHQ-9 measures depression. The GAD-7 measures anxiety. Both are free to reproduce, both are used everywhere, and both take about three minutes.

Answer for **the last two weeks**. Score each one: **Not at all = 0**, **Several days = 1**, **More than half the days = 2**, **Nearly every day = 3**. Then add them up.

One note on the questionnaire you may have already met. The Edinburgh Postnatal Depression Scale is the most widely used tool in this period, but it is copyrighted by the Royal College of Psychiatrists and cannot be reprinted here. If a clinician hands you one, there is a scoring calculator on our website that will total it for you.

PHQ-9 — Depression

Over the last two weeks, how often have you been bothered by any of the following problems?

1. Little interest or pleasure in doing things
2. Feeling down, depressed, or hopeless
3. Trouble falling or staying asleep, or sleeping too much
4. Feeling tired or having little energy
5. Poor appetite or overeating
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down
7. Trouble concentrating on things, such as reading the newspaper or watching television
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual
9. Thoughts that you would be better off dead or of hurting yourself in some way

If your answer to question 9 was anything other than "not at all," that matters more than your total score, and it deserves a response today rather than at your next appointment. Call or text **988**, or call the National Maternal Mental Health Hotline at **1-833-852-6262**. You are not in trouble, and you will not lose your baby for saying this out loud.

What the total means

SCORE	SEVERITY
0–4	Minimal
5–9	Mild
10–14	Moderate
15–19	Moderately severe
20–27	Severe

A score of **10 or higher** is the usual threshold for a closer look. At that cut point the PHQ-9 runs about 88% sensitivity and 88% specificity — and notably, it was validated across obstetrics and gynecology clinics as well as primary care, performing similarly in both.

One caveat worth carrying into the appointment. Several of these items ask about sleep, energy and appetite — all of which a newborn wrecks regardless of your mood. If your score is driven mostly by those, say so. If it is driven by items 1, 2, 6 and 9, that is considerably stronger evidence, and worth pointing at directly.

GAD-7 — Anxiety

Over the last two weeks, how often have you been bothered by the following problems?

1. Feeling nervous, anxious, or on edge
2. Not being able to stop or control worrying
3. Worrying too much about different things
4. Trouble relaxing
5. Being so restless that it's hard to sit still
6. Becoming easily annoyed or irritable
7. Feeling afraid as if something awful might happen

What the total means

SCORE	SEVERITY
0–4	Minimal
5–9	Mild
10–14	Moderate
15–21	Severe

A score of **10 or higher** is the usual threshold, with about 89% sensitivity and 82% specificity there.

This questionnaire is in the book for a specific reason. Routine screening after birth is built around depression — so a woman who is frightened rather than sad hands in her form and is told the number

looks fine. If that has happened to you, this is the page to bring back.

What to Bring to the Appointment

Fifteen minutes goes faster than you think. Walking in with this written down changes what those minutes can hold.

- Your PHQ-9 and GAD-7 scores, and the date you took them
- When the symptoms started, and what has changed since
- How much you are actually sleeping — separate from how much the baby is
- Every medication and supplement you take, with doses
- Any previous episode of depression or anxiety, and what helped or didn't
- Family history of depression, bipolar disorder, or postpartum mental illness
- Whether you are breastfeeding, and whether you want to continue

Questions worth asking

- "Based on this, what do you think is going on?"
- "What are my options, and what would you suggest first?"
- "How long before I should expect to feel a difference?"
- "What should I do if I feel worse before then?"
- "Can I take this while breastfeeding?" — naming the specific drug
- "When should I come back?"

You can bring someone with you. You can ask for a longer appointment when you book it. And you can open with the plainest sentence in this book: that you would like to be screened today.

One Last Thing

If you are reading this at three in the morning with a baby on your chest, wondering whether what you feel is normal — the fact that you are asking is not evidence that you are failing. It is the most common reason anyone opens this book.

Here is where we started, and it is worth ending on. Most women get better with treatment. Most women with symptoms are never diagnosed at all. Everything difficult about this illness lives in the space between those two sentences.

And that space is closeable. Not by being stronger, or more grateful, or better at any of this than you already are. Usually by one sentence, said out loud, to one clinician, on one ordinary afternoon.

Saying it does not put your baby at risk of being taken. Saying it is the thing that gets you help.

Jenna wrote her first post eight months in, with no idea how it ended. Thirteen months later she wrote the second one. You are somewhere on that same road, and the fact that you cannot yet see the end of it is not evidence that it doesn't have one.

988 — Suicide & Crisis Lifeline. Call or text. Free, confidential, 24 hours a day.

1-833-TLC-MAMA (1-833-852-6262) — National Maternal Mental Health Hotline. Call, text or chat. English and Spanish, 24 hours a day.

1-800-944-4773 — Postpartum Support International HelpLine. Not a crisis line, but the best route to local perinatal specialists.

Text HOME to 741741 — Crisis Text Line.

911 — immediate danger.

Every topic in this guide is covered in more depth, with full citations, at **PostpartumDepression.org** — including a directory of therapists who specialize in perinatal mental health, searchable by state and city.

Sources

Every figure in this guide is drawn from the published research below. Full citations, with links, are maintained on the corresponding pages at PostpartumDepression.org.

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This guide is for information and is not a substitute for medical advice, diagnosis or treatment from a qualified clinician. If you are in crisis, call or text 988.