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Testimony of

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On

**The Melanie Blocker-Stokes
Postpartum Depression Research and Care Act
(H.R. 20)**

**Before the United States
House of Representatives
Committee on Energy and Commerce
Subcommittee on Health**

May 1, 2007

Good afternoon, Chairman Pallone, Vice Chairman Green, Ranking Member Deal, and members of the Health Subcommittee. I am honored to appear before you today.

My name is Nada L. Stotland, M.D. I hold Doctor of Medicine and Master of Public Health degrees and have been a practicing psychiatrist for more than 25 years. Currently, I have a private clinical practice and have devoted most of my career as a physician to the psychiatric aspects of women's reproductive health care.

I speak today on behalf of the American Psychiatric Association (APA), where I presently serve as an elected member of the Board of Trustees. APA is the medical specialty society representing more than 38,000 psychiatric physicians nationwide. Our members are on the front lines of treating mental illness across the country. They serve as clinicians, academicians, researchers, and administrators.

By way of personal background, my interest in women's reproductive health issues began with the personal psychology of pregnancy, labor, and childbirth. I gave birth to four wonderful daughters, now adults, and I was determined that their births be as safe as possible. I studied methods of prepared childbirth, used them, and became the Vice President of the national Lamaze prepared childbirth organization. My daughter Naomi is now an obstetrician/gynecologist and the mother of two children of her own.

I commend the Subcommittee for holding this important hearing on post-pregnancy mental health in women. Before I begin my testimony, I want to take a brief moment to acknowledge the determined persistence of my own Congressman and a member of the Committee – Representative Bobby Rush – in reintroducing H.R. 20 and in continuing his personal efforts to move his bill through the House. I greatly appreciate his leadership on this vital issue, particularly with respect to the impact of untreated depression in minority populations, including minority women. This is an important and sorely neglected issue.

Mental Health Issues and Women:

Before focusing on post-pregnancy depression, it would be useful to discuss some general issues related to women's mental health. Burt and Hendrick, writing in their "Concise Guide to Women's Mental Health," put it succinctly, noting that "Women use more health care services than any other group in the United States. They make more visits to doctors' offices than do men, fill more prescriptions, have more surgeries . . . and spend two out of every three health care dollars."

Specific gender differences in the prevalence of mental illnesses in the United States are well recognized. This is true of prevalence rates for some disorders, but also in the way in which some disorders present at the diagnostic interview, and also in comorbidities. For example, not only are depression and dysthymia (a chronic form of depression) more common in women than men, but both are more likely to be accompanied by anxiety disorders in women than men. And the features of psychiatric illnesses present in women are likely to be different than when present in men.

The landmark Surgeon General's Report on Mental Health, issued by then-Surgeon General David Satcher, M.D., in 1999, provides much valuable information. Anxiety disorders (panic disorder, phobias, obsessive compulsive disorder, panic disorder, PTSD, etc.) are the most prevalent disorders in adults and are found twice as often in women as in men. Panic disorder is about twice as common among women as men, with the most common age of onset between late adolescence and mid-adult

life. In the general (non-military) population, the one-year prevalence rate of posttraumatic stress disorder is about 3.6 percent, with women accounting for nearly twice the prevalence as men. The highest rates of PTSD are found among women who are the victims of crime, especially rape.

Mood disorders take a huge toll in the form of human suffering, lost productivity and suicide. They rank among the top ten disabling conditions worldwide. The most familiar mood disorders include major depression, dysthymia and cyclothymia (alternating depression and manic states that do not rise to the level of bipolar disorder). Again, with the exception of bipolar disorder, mood disorders are twice as common in women as in men, and in the case of seasonal affective disorder (depression occurring in the late fall and winter), seven times more common in women than men. Victims of domestic violence (an estimated 8 to 17 percent of women in the United States each year) are at increased risk for mental health problems. The mental health problems of domestic violence include depression, anxiety disorders including as noted PTSD, eating disorders, substance abuse and suicide.

Few would doubt the huge impact of depression alone on society and on the economy. Major depression is a seriously debilitating illness. Depressed persons see their physicians more often than others, and misdiagnosed depression can lead to extensive, expensive diagnostic tests (with obvious implications for health care costs). The most serious consequence of untreated depression is suicide. Major depressive disorders account for up to one-third of all deaths by suicide. While men in the U.S. commit suicide four times as often as women, women *attempt* suicide four times as often as men.

The Importance of the Diagnostic and Statistical Manual of Mental Disorders (DSM):

Psychiatrists and other mental health professionals depend on accurate diagnostic tools to help them identify precisely the mental illnesses their patients suffer, an essential step in deciding what treatment or combination of treatments the patient needs. The Diagnostic and Statistical Manual of Mental Disorders (or DSM) has become a central part of this process. DSM is, simply, the internationally-recognized standard for the diagnosis of mental disorders. As such, it provides the most comprehensive diagnostic framework for defining and describing mental disorders. DSM-IV is embodied in over 650 state and federal statutes and regulations.

The DSM-IV is based on decades of research and was developed through an open process involving more than 1,000 national and international researchers and clinicians drawn from a wide range of mental and general health fields. The special 27-member DSM-IV Task Force worked for five years to develop the manual in a process that involved 13 work groups, each of which focused on a section of the manual. I myself was a member of the work group addressing late luteal phase dysphoric disorder, or premenstrual dysphoric disorder, as it came to be known. The work groups and each of their advisory groups of 50 to 100 individuals developed the manual in a three-step process.

The first step in the three-stage empirical review was the development of 150 reviews of the scientific literature, which provided the empirical database upon which DSM-IV decisions could be made. In the second step, task force work groups reanalyzed 50 separate sets of data which provided additional scientific information to that available in the published literature. Finally, the task force conducted 12 field trials with funding from the National Institute of Mental Health, National Institute on Drug Abuse, and the National Institution of Alcoholism and Alcohol Abuse, involving more than 88 sites in the United States and internationally and evaluations of more than 7,000 patients. As you can see, the DSM-IV is based on systematic, empirical studies.

The DSM-IV's codes are in agreement with the International Classification of Diseases, Ninth Edition, Clinical Modification (ICD-9-CM). ICD-9-CM is based on the ICD-9, a publication of the World Health Organization, used worldwide to aid in consistent medical diagnoses.

The DSM-IV's codes often are required by insurance companies when psychiatrists, other physicians and other mental health professionals file claims. The Centers for Medicare and Medicaid Services (CMS) require mental health care professionals to use the DSM codes for the purposes of Medicare reimbursement.

DSM and Depression and Psychosis:

One of the more unfortunate aspects of our culture is that we tend to use diagnostic terms in everyday language. We say, for example, that a student who gets a "C" on a mid-term is "depressed," or that someone who is acting in an agitated way is "psychotic." Doing so underscores a misunderstanding of the terms and thus embodies the stigmatic way in which we too-often approach mental illnesses. For purposes of today's hearing it may be useful to briefly discuss depression and psychosis in the context of the DSM.

Depression: When used to describe a mood, *the word "depression" refers to feelings of sadness, despair, and discouragement.* As such, depression may be a normal state of feelings which any person could experience from time to time. *"Depression" is also a clinical and scientific term, and in these contexts may refer to a "symptom" seen in a variety of mental or physical disorders, or it may refer to a "mental disorder" itself.* DSM-IV classifies depression by severity, recurrence, association with mania, and time of occurrence, including after the birth of a baby.

Psychosis: *Psychosis is part of a severe mental disorder and is characterized by a person's gross impairment in perceiving reality.* A psychotic person may be delusional or may experience hallucinations, disorganized speech, or disorganized or catatonic behavior. Psychosis may show up, for example, in patients who are suffering from schizophrenia, delusional disorders, and some mood disorders including manic-depression or bipolar disorder.

Postpartum Psychiatric Disorders:

Mental disorders following childbirth was first mentioned over 400 years before the birth of Christ, by Hippocrates, who described the case of a woman in Cyzicus who "gave birth with difficult labor," became sleepless and wandered at night, eventually suffering great distress before becoming rational again.

Today we know from research that disturbances can occur in the postpartum period in the form of "baby blues," or more seriously as postnatal depression or psychosis. Onset of baby blues occurs within days of delivery and can impact a significant number (some suggest 28 to 80 percent) of mothers across cultures. Features include emotional lability; it is unrelated to past history, and the symptoms are self-limited. Women with baby blues benefit from reassurance that the symptoms are common and will quickly disappear, but should be advised to seek help if symptoms are severe or persist for more than two weeks.

Postpartum depression is an affective disorder lasting more than two weeks, typically with an onset beginning two to four weeks postpartum, the severity of which meets criteria for DSM-IV designation.

Special attention to postpartum depression is warranted because – in addition to the impact on maternal general and mental health – it increases the risk of negative parenting behaviors and puts children at risk for adverse outcomes in social, emotional, and behavioral development. Many cases are missed because new mothers are discharged so quickly from the hospital, and thereafter most care is provided by physicians focused on the care and wellness of the infant, and many families are uninformed about the nature and occurrence of the disorder. The literature shows risk factors including financial hardship, physical and emotional abuse, and a previous history of depression, particularly depression occurring antepartum.

Postpartum psychoses are psychotic disorders arising after childbirth. These are acute, severe illnesses occurring after one or two of every 1,000 births. Symptoms include mood lability, severe agitation, confusion, thought disorganization, hallucinations and sleeplessness. Most researchers believe that postpartum psychosis is a manifestation of bipolar disorder. These episodes of psychotic illness are triggered by the biologic and psychological stresses of pregnancy and delivery. The results of misdiagnosed psychosis occurring postpartum or lack of access to effective treatment can be, frankly, horrific, with some mothers committing infanticide followed (in up to 62 percent of the cases) by suicide. Sadly, several such cases have occurred among Representative Rush's constituents.

One important factor in responding appropriately to postpartum disorders is to call attention to their existence. New mothers need to understand the difference between “the blues” and feelings of overwhelming and persistent sadness. Physicians can help by preparing their patients with some reassuring but straight talk about the fact that childbirth and new parenthood can indeed be stressful and reactions to motherhood can't always be predicted. Peripartum emotional support is important; families should be included in education efforts, assessment of possible risks, and in the provision of supports. In particular, efforts by policymakers to call attention to the problem are most welcome and helpful.

What can be Done to Help?

Postpartum depression (and the rarer postpartum psychosis) cause needless hurt, misery, and at the extremity, serious injury and even death. First, we need to recognize that these illnesses are absolutely real. As I suggested at the start of my testimony, we have a tendency to incorporate psychiatric terminology into everyday use, using words like “depressed” or “psychotic” in non-clinical ways that misstate and distort their meaning. The same is true of the overuse of the term “baby blues” to colloquially mean anything and everything from transient mild sadness to severe and persistent postpartum depression. Both examples reflect stigma about mental illness and desensitize us to the potentially serious consequences of untreated postpartum depression or psychosis.

Second, we need to take postpartum mental health seriously. If there is any evidence of postpartum difficulties, new mothers should be screened for depression. To achieve this objective, we need to help educate patients, families, and health professionals about the warning signs that a new mother's “baby blues” may, in fact, be a much more serious condition.

I want to call your attention to a recent press release from the Health Resources and Services Administration (HRSA), announcing a publication entitled “Depression During and After Pregnancy: A Resource for Women, Their Families, and Friends.” This 20 page booklet can be downloaded in PDF format at: www.mchb.hrsa.gov/pregnancyandbeyond/depression.

It is a well-written resource that addresses postpartum mental health in a straightforward, non-alarmist way that even includes a simple self-assessment screening instrument to help women recognize that they may need help. I have a copy with me and would be glad to leave it with you for inclusion in the record of today's hearing. It really ought to be widely publicized to physicians, nurses, clinics, hospitals, and community health and mental health centers. I'd like to commend HRSA for producing the pamphlet.

Third, the Subcommittee should move forward with H.R. 20, which Representative Rush has pursued so passionately. The bill lays out a straightforward agenda for research, resource coordination, and improved services to improve the diagnosis and treatment of postpartum depression, and – most importantly – to fund programs to establish and operate programs and systems of care for treating postpartum depression and postpartum psychosis. These include:

- Outpatient and home-based health services
- Case management
- Screening
- Comprehensive treatment services
- Inpatient care management
- Assisted homemaker services
- Respite or daycare
- Family supports

These practical and mostly low-cost proposals would go a long way toward bringing care where it is needed, particularly to lower-income and/or minority populations who may not have the necessary access to services or the means to secure what is needed.

If I might, I'd like to make one suggestion, and that is to include provisions to fund programs to ensure that physicians and other health professionals are fully trained to recognize the possible presence of serious postpartum mental health issues, and thus be able to refer for appropriate follow-up and treatment by psychiatrists or other mental health professionals qualified to provide such care. APA would be glad to work with the Subcommittee if it would be helpful.

Finally, the Subcommittee and the full Congress must recognize that the best diagnostic criteria are useless if women can't get treatment because their health insurance discriminates against treatment of mental illness. It is long-past time to eradicate stigma-driven insurance discrimination and provide for treatment of mental illnesses in the same way that we do other medical/surgical care. Patients should not have to pay more for mental health care, and they should not get less of what they need. Committees in the House including your own are poised to take up mental health parity legislation, and as you know the Senate Committee on Health, Education, Labor and Pensions has already approved the Kennedy-Domenici bill, S. 558. I urge the House to quickly follow suit, and to follow the Kennedy-Ramstad bill with legislation to end similar discrimination against psychiatric care in the Medicare program.

Conclusion:

Mr. Chairman, as a woman, as a physician, and particularly as a psychiatrist, I have great sympathy and compassion for all of my patients, women and men, adults and adolescents, who struggle with mental illnesses. The Melanie Blocker-Stokes Postpartum Depression Research and Care Act offers hope and practical solutions for women who need help, and I hope the Subcommittee will move forward with the agenda in the bill.

Again, if this Congress wants to take one single action that would make a world of difference for all women – for all persons – seeking treatment for mental disorders, I respectfully suggest that the right action would be to enact a federal law requiring non-discriminatory coverage of treatment of mental illnesses as part of all insurance. It is time to end the artificial mind/ body split in insurance coverage. Well over half the House of Representatives and more than two-thirds of the Senate have cosponsored legislation in this or previous Congresses to achieve this result. On behalf of my patients, I respectfully urge you to address the unmet mental health needs of the nation's women, and men, children and adolescents, by enacting non-discriminatory coverage of treatment of mental illnesses.

Thank you again for the opportunity to speak with you today. I would be happy to answer any questions you or other members of the Subcommittee may have.

Depression During and After Pregnancy



**A Resource for Women, Their Families,
and Friends**





“I have trouble eating and sleeping. I feel lonely, sad, and don’t have the energy to get things done. Sometimes I don’t even want to hold my baby. If this is supposed to be the happiest time of my life, why does everything feel so wrong?”

For many mothers, the experience of pregnancy and childbirth is often followed by sadness, fear, anxiety, and difficulty making decisions. Many women have difficulty finding the energy to care for themselves, their infants, and their families. Some even have feelings about harming themselves and their children.

If this sounds like you or someone you know, there are two important things you should know.

You are not alone.
Help is near.





Did things change after you became pregnant? Are things different than you expected as a new mother? Are you tired, anxious, sad, and confused? This booklet will begin to explain the possible causes for your feelings—and more importantly—how to find the help you need.

Depression during or after pregnancy refers to a broad range of physical and emotional struggles that many women face. You may have heard this called the “Baby Blues,” Postpartum Depression, Maternal Depression, Prenatal Depression, Postnatal Depression, or Perinatal Depression. In this booklet, we will call it **Perinatal Depression**.

Perinatal Depression can be mild, moderate or severe. It can occur during pregnancy or within a year after the end of your pregnancy. Without treatment, symptoms may last a few weeks, months, or even years. In rare cases, the symptoms are severe and indicate potential danger to the mother and baby. **In all cases, help is available.**





“Everybody expects me to be the perfect mother, but I just can’t do it. Sometimes I feel like I can’t even care for my baby.”

What Causes Perinatal Depression?

There are a number of reasons why you may get depressed. As a woman, your body undergoes many changes during and after pregnancy. You may experience mood swings. A new baby will change your sleeping schedule and your lifestyle. In addition, there are many pressures to be the perfect mother.

Some women have family members with depression, some women have had depression in their own past, and for some women, the cause is unclear. But for every woman who suffers Perinatal Depression, the causes are as unique as she is.

Perinatal Depression – It's More Than the Baby Blues

Many new mothers experience the Baby Blues. This is a very common reaction during the first few days after delivery. Symptoms include crying, worrying, sadness, anxiety, mood swings, trouble concentrating, difficulty sleeping, and not feeling yourself.

The Baby Blues is not the same as Perinatal Depression and does not require medical attention. With time, patience, and the support of family and friends, symptoms linked with the Baby Blues will usually disappear within a few days or within 1 to 2 weeks. If they don't, it may be a sign of a bigger problem, and you should seek medical help.





“I was so excited I decorated the nursery months before the baby arrived. But when she came, it was not a dream. I had no energy to smile or even to cry. I didn’t even want to pick her up. This was not how I thought it was going to be, and I was ashamed of how I felt.”

Who Is at Risk?

Perinatal Depression can affect any woman—regardless of age, race, income, culture, or education. It affects women who breastfeed and those who don't. It affects women with healthy babies and those whose children are ill. It affects first-time mothers and those with more than one child. It affects women who are married and those who are not. Women who had problems during pregnancy—and those who didn't—may experience depression. Because Perinatal Depression is a health problem, **it is not the fault of any woman.**

A family history of depression or bipolar disorder, a history of alcohol or drug abuse, a recent stressful event, relationship or financial problems, or a previous pregnancy with Perinatal Depression increases a woman's chances of having Perinatal Depression.

Types of Perinatal Depression

Even before the arrival of the baby, some women experience **Depression During Pregnancy.** Pregnant women commonly face a large number of challenges, including morning sickness, weight gain, and mood swings. Symptoms such as feeling really tired, appetite changes and poor sleep are often dismissed as “just part of pregnancy,” but if the things you do every day are affected, you should consider seeking help. Whether the pregnancy was planned or unexpected, the changes that your body and emotions go through during pregnancy are very real—and so are the risks of Perinatal Depression during this time.





“I just wish that I could laugh and be happy. When will my sadness go away?”

About one in eight women suffers a form of Perinatal Depression known as **Postpartum Depression**. Symptoms can begin at birth or any time in the first year after giving birth.

Common symptoms for perinatal depression include:

- Sad feelings
- Feeling very anxious or worrying too much
- Being irritable or cranky
- Trouble sleeping (even when tired) or sleeping too much
- Trouble concentrating or remembering things
- Trouble making decisions
- Loss of interest in caring for yourself (for example, dressing, bathing, fixing hair)
- Loss of interest in food, or overeating
- Not feeling up to doing everyday tasks
- Frequent crying, even about little things
- Showing too much (or not enough) concern for the baby
- Loss of pleasure or interest in things you used to enjoy (including sex)

A very small number of women (one or two in 1000) suffer a rare and severe form of Perinatal Depression called **Postpartum Psychosis**. Women who have a bipolar disorder or other psychiatric problem may have a higher risk for developing this form of Perinatal Depression. Symptoms of Postpartum Psychosis may include:

- Extreme confusion
- Hopelessness
- Cannot sleep (even when exhausted)
- Refusing to eat
- Distrusting other people
- Seeing things or hearing voices that are not there
- Thoughts of hurting yourself, your baby, or others

If you or someone you know fits this description, please seek medical help immediately. This is a medical emergency requiring URGENT care.



Am I a Good Mother?

“I was worried about what would happen if people thought I couldn’t be a good mother. But when I got help, I realized that I was still the one in control.”

How Do I Know if I Have Perinatal Depression?

Only a trained health care or mental health professional can tell you whether you have Perinatal Depression. However, the following checklist can help you know whether you have some of the common symptoms. Mark the box if the statement sounds familiar to you.

During the past week or two –

- I have been unable to laugh and see the funny side of things.
- I have not looked forward to things I usually enjoy.
- I have blamed myself unnecessarily when things went wrong.
- I have been anxious or worried for no good reason.
- I have felt scared or panicky for no good reason.
- Things have been getting the best of me.
- I have been so unhappy that I have had difficulty sleeping.
- I have felt sad or miserable.
- I have been so unhappy that I have been crying.
- The thought of harming myself, my baby, or others has occurred to me.

Did you check more than one box? If so, we encourage you to visit with a trained health care or mental health care professional who can help determine if you are suffering from Perinatal Depression and advise a course of action.

Checklist adapted from the Edinburgh Postnatal Depression Scale. Cox, J.L., Holden, J.M. & Sagovsky, R. (1987). "Detection of Postnatal Depression: Development of the 10-item Edinburgh Postnatal Depression Scale." *British Journal of Psychiatry*, 150,782-876.





“Some of the symptoms sounded just like me. I knew it was important to talk to my doctor.”

If I Have Perinatal Depression, What Can I Do?

Some women may find it hard talking about Perinatal Depression. They may be unsure if they have it or how to discuss it. They may wish to deal with their problem secretly and hope that it goes away on its own.

These feelings are more common than one would expect. However, every woman must realize that she is not alone. Perinatal Depression affects thousands of women and can be treated successfully. It *is* possible to feel better. Here are some things that can help.

1. Lean on Family and Friends

There are many ways that family and friends can help you. A few hours of weekly child care can give you a much-needed break. Get help cleaning the house or running errands. When you share your feelings openly with friends and family, it allows them to provide the important support that you need.

2. Talk to a Health Care Professional

Screening for Perinatal Depression should be a routine part of your health care during and after pregnancy. Health care professionals—such as your doctor, your baby’s doctor, a nurse, or other health care provider—are familiar with Perinatal Depression. They know ways to help, and can explain your options to you. An easy way to raise the subject is to bring this booklet with you to the provider’s office. Show the items that you checked and discuss them. Say that you were reading the booklet and some of it sounds familiar to you. If you feel that your provider does not understand what you are going through, please do not give up. There are many excellent providers who *do* understand Perinatal Depression, who are ready to listen to you, and who can put you on the road to recovery.





“Meeting with my support group is the best part of the week. When I found women going through the same things as me, I didn’t feel so lonely any more. Now we are moving forward together, hand in hand.”

3. Find a Support Group

Although you may not know it, there are probably other women in your community suffering from Perinatal Depression. Finding them can give you a chance to learn from others and to share your own feelings. Ask your health care professional how to find and join a support group.

4. Talk to a Mental Health Care Professional

Many mental health professionals have special training to help women with Perinatal Depression. They can give you a safe place to express your feelings and help you find the best ways to manage and even get rid of your symptoms. When choosing counselors or other professionals, ask if they have experience in treating Perinatal Depression. They have helped other women with depression and they can help you too!

5. Focus on Wellness

An important step toward treating Perinatal Depression is taking care of your body. A healthy diet combined with exercise can help you gain your lost energy and feel strong. Consider these suggestions:

Food

- Eat breakfast in the morning to start your day right
- Eat a variety of foods from all food groups, including two servings of fruit and three servings of vegetables each day
- Choose healthy snacks like non-fat milk, yogurt, fruit, and nuts
- Avoid alcohol use





“When my doctor suggested taking medicine, I wasn’t sure. But it turned out to be the best decision for me. I feel so much better now.”

Exercise

- Invite your friends to go on walks in your neighborhood or to the park
- Try a new activity, such as swimming or biking
- Take time to stretch and strengthen your muscles

In addition, by prioritizing the most important things in your life and letting go of what is least important, you can clear your mind to focus on your own health and well-being.

6. Take Medication as Recommended by Your Health Care Provider

Sometimes medications are necessary in the treatment of depression. As with any medications or medical treatment, you should talk to your health care provider about which medication, if any, may be best for you. Become an educated consumer and find out information about treatment options.

Additional information resources are available on page 21 of this booklet.

How Can Perinatal Depression Affect My Baby and My Family?

The symptoms of Perinatal Depression often create a very difficult situation for families. For infants, the effects of Perinatal Depression can be serious. There is a greater chance of babies arriving too small or too early, or having problems in learning and behavior as they grow older. Older children suffer when they lose the attention and support of their mother. Loved ones suffer because they don't know what to do or how to help. Other family members are often called upon to fill the gap. Because Perinatal Depression affects the entire family, it is critical that family members recognize the symptoms and help their loved one seek help.





“Something wasn’t right in our family. She felt so much sadness instead of joy. Together we decided to get help. Now that I understand what is happening, I can offer her more of the support she needs.”

Advice for Fathers, Family, and Friends

If you know a woman who has the symptoms of Perinatal Depression, this is how you can help.

As a Spouse or Partner:

- **Encourage her to seek help.** This is the quickest path to recovery.
- **Offer support and encouragement.** Your positive actions and words can reduce some of her suffering.
- **Listen.** Her feelings are real. Let her express them to you.
- **Allow her to focus on her own needs.** Physical and social activities help women suffering from Perinatal Depression feel stronger, more relaxed, and better about themselves.
- **Take time for yourself.** It is important for spouses and partners to continue with their work, hobbies, and outside relationships.

As a Friend or Family Member:

- Ask the mother how you can help, including baby-sitting and house cleaning.
- Let her know you are there for her, even if she doesn't like talking.
- Understand that the father may also feel stressed from the changes that come with being a new father or by a partner who is suffering from Perinatal Depression.

Where Can I Get More Information?

There are many excellent resources on Perinatal Depression. At your local public library, you can use the Internet or check out books to get important information. There are telephone hotlines and support services where you can ask questions. Also, your health care provider may have additional resources. The more you understand about Perinatal Depression, the better you will be able to care for yourself and the ones you love. A list of resources is located on page 21.





“I recognized the symptoms and took charge. It was not easy, but with support from my family, friends, and doctors, and drawing on my own personal strength, I overcame Perinatal Depression and today I am moving forward. My family is well. My baby is well. And most importantly, I am well.”

Where Help is Available

Postpartum Support International

Phone: 800-944-4PPD (800-944-4773) / **Internet address:** [http:// www.postpartum.net](http://www.postpartum.net)
For information on treatment, support groups and resources in the United States and 25 countries.

Postpartum Education for Parents

Phone: 805-967-7636 / **Internet address:** <http://www.sbpep.org>
A 24-hour support line is available for one-to-one support, from basic infant care to the baby blues and other perinatal topics.
(This may be a Long Distance call.)

1-800-311-BABY (1-800-311-2229)

(In Spanish: 800-504-7081)
For information on prenatal services in your community.

Additional Resources

National Mental Health Association

Phone: 800-969-NMHA (800-969-6642) / **Internet address:** <http://www.nmha.org>
For information on Perinatal Depression, including a locator to find a mental health center or provider in your area.

SAMHSA National Mental Health Information Center

Phone: 800-789-2647 / **Internet address:** <http://mentalhealth.samhsa.gov>
For information on depression, including a locator to find a mental health center in your area.

National Women's Health Information Center

Phone: 800-994-WOMAN (800-994-9662)
Internet address: <http://www.4woman.gov> or <http://www.womenshealth.gov>
Frequently asked questions about depression and pregnancy are available on the Web site.

National Institute of Mental Health

Phone: 866-615-6464 / **Internet address:** <http://www.nimh.nih.gov>
The Web site has links to health information and research studies on depression.

American College of Obstetricians and Gynecologists (ACOG)

Phone: 800-762-2264 / **Internet Address:** <http://www.acog.org>
Resources for you and your health care provider.

Books

Beyond the Blues, by Shoshana S. Bennett and Pec Indman (Moodswing Press, 2006)
Available in Spanish

Beyond the Birth, by Dawn Gruen, Rex Gentry, Abby Meyers, and Sandra Jolley
(Depression After Delivery, 2003)

Books are available online at: <http://www.ppm-support.com/resource.php>



Depression During and After Pregnancy

A Resource for Women, Their Family, and Friends



The information in this booklet is not a substitute for personal medical advice, attention, diagnosis or treatment. If you have questions or concerns about your health or the health of your baby, consult your health care professional.



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Health Resources & Services Administration
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This booklet is available at www.mchb.hrsa.gov/pregnancyandbeyond/depression
Print Copies can be obtained from the HRSA Information Center 1-888-Ask-HRSA