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Recognizing the Symptoms of Postpartum Depression

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Abstract

Postpartum depression (PPD) is a common yet often overlooked mood disorder that affects both mothers and fathers following childbirth. While society portrays new parenthood as a time of joy, some individuals struggle with persistent sadness, anxiety, and emotional detachment, which makes it challenging for them to care for themselves and their newborns. PPD differs from the normal adaptation period referred to as "baby blues" in its duration and severity. Despite its recognition in mothers, paternal PPD remains underdiagnosed, with many fathers suffering in silence due to stigma and a lack of awareness. Contributing factors to PPD include hormonal fluctuations, sleep deprivation, complicated childbirth, and insufficient social support. This paper explores the symptoms, risk factors, gender-specific differences in PPD, and various treatment options. It highlights the importance of early recognition, timely interventions, and destigmatization to improve parental mental health and overall family well-being.

Keywords: postpartum depression, baby blues

The birth of a child is often seen as a time of immense joy, but for many new parents, it can bring unexpected emotional challenges. A few days after childbirth, many parents, especially mothers, may experience mood swings, depressive symptoms, irritability, and anxiety that are commonly referred to as the “baby blues” (Luciano et al., 2021). This is considered a normal response to hormonal changes and the stress of parenthood, which usually resolves naturally within a few weeks without medical intervention (Luciano et al., 2021). However, in some cases, this does not happen, and baby blues can progress to postpartum depression.

Postpartum depression (PPD) is a common yet often overlooked mood disorder that can affect both mothers and fathers after childbirth (Eddy et al., 2019; Smythe et al., 2022). Research indicates that approximately 10–20% of mothers and 5–10% of fathers experience some level of postpartum depression symptoms, ranging from persistent sadness and anxiety to extreme fatigue and difficulties bonding with their child (Branquinho et al., 2022; Eddy et al., 2019; Luciano et al., 2021). Despite societal expectations that new parents should be overwhelmed with happiness, many struggle with feelings of despair, guilt, and emotional detachment, making it difficult to care for themselves and their newborn. This societal pressure and stigma surrounding new parenthood often lead to PPD being underdiagnosed and, consequently, undertreated. Several factors contribute to this issue, including the stigma associated with mental health, societal expectations, limited awareness of what is considered normal, and concerns about the effects of treatment (e.g., antidepressants) on breastfeeding (Werner et al., 2015).

The Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR) does not classify PPD as a separate disorder (American Psychiatric Association [APA], 2022). Instead, it defines PPD as a subset of major depressive disorder with peripartum onset, which refers to depression that occurs during pregnancy or within the first few weeks postpartum (Demirci & İnan, 2023; Dillon et al., 2022; Scarff, 2019). Although PPD is widely recognized in new mothers, there is still a lack of awareness about PPD in men, which can leave many fathers suffering in silence (Dillon et al., 2022; Eddy et al., 2019). Hence, PPD not only affects parents' well-being but also negatively impacts family dynamics and infant development. Specifically, it

negatively impacts the relationship between infant and parent (Branquinho et al., 2022; Werner et al., 2015). Parents who experience PPD often face emotional distress, difficulty bonding with their baby, and disruptions in daily functioning. While the exact causes of PPD are complex and multifaceted, several risk factors might contribute to PPD, such as complicated pregnancy or birth, lack of social support, and sleep deprivation (Werner et al., 2015).

This article examines the symptoms and interventions of postpartum depression, how it differs from "baby blues," its impact on both mothers and fathers, and treatment options. By increasing awareness of PPD in both men and women, we can promote early recognition of symptoms, provide timely support, and implement interventions that may prevent the progression of PPD.

How to Differentiate PPD from "Baby Blues"

Many new mothers experience mood swings, depressive symptoms, anxiety, insomnia, and weepiness in the days following childbirth, commonly known as the baby blues or maternity blues (Luciano et al., 2021). These mood swings are considered a normal response to hormonal fluctuations, disrupted sleep, and the stress of caring for a newborn. Baby blues are not viewed as a mental disorder due to their short duration, lower symptom intensity, and the fact that they usually resolve on their own without treatment or medical intervention (Luciano et al., 2021). In contrast, the baby blues represent a temporary adjustment period, whereas PPD is a more severe and persistent mental health condition that requires attention and intervention due to its significant impact on daily functioning and parent-infant bonding (Luciano et al., 2021; Wells & Jeon, 2023).

The primary distinction between PPD and the baby blues is the duration and intensity of their symptoms. Baby blues typically last from a few days to two weeks, resolving without any medical attention, whereas PPD can last from weeks to months and requires medical intervention. Additionally, symptoms of baby blues (e.g., mood swings and fatigue) are milder and less intense than those of PPD (Luciano et al., 2021). For example, new parents experiencing baby blues can still find joy in parenthood and function in daily life, whereas people suffering from PPD often struggle with both aspects (Branquinho et al., 2022; Werner et al., 2015).

Although the baby blues are considered a normal reaction to postpartum hormonal changes and emotional adjustments, in some cases, they can be a precursor to PPD, making early intervention and monitoring essential (Luciano et al., 2021). When symptoms such as fatigue, weepiness, insomnia, and anxiety persist beyond two weeks and feel intense and even overwhelming, it might indicate the onset of PPD. Therefore, careful monitoring during the early postpartum period is critical to identifying individuals at risk and implementing interventions that may prevent more severe symptoms (Luciano et al., 2021; Werner et al., 2015).

PPD Symptoms

Emotional and Psychological

One of the defining characteristics of PPD is persistent emotional and psychological distress, including prolonged sadness, irritability, and a diminished ability to experience pleasure or connect with their newborn (American Psychiatric Association, 2022; Branquinho et al., 2022). New mothers may experience a deep, unshakable feeling of despair that lingers beyond the transient mood fluctuations seen in the baby blues (Luciano et al., 2021). These severe and persistent symptoms interfere with a parent's ability to function in daily activities and bond with their newborn. While symptoms vary between individuals, some of the most commonly reported symptoms include sadness, hopelessness, anxiety, irritability, inadequacy, and worthlessness (Eddy et al., 2019; Scarff, 2019; Wang et al., 2021).

Individuals with PPD often experience profound and persistent sadness, accompanied by a sense of hopelessness (Branquinho et al., 2022; Dillon et al., 2022). Such individuals may feel that happiness is unattainable and might doubt their ability to care for their child (Branquinho et al., 2022). Additionally, PPD is frequently associated with excessive anxiety and worry about the baby's health, development, or well-being. This level of anxiety exceeds typical parental concerns and can become obsessive, sometimes leading to panic attacks or sleep disturbances (Werner et al., 2015). Constant worry and fear may sometimes lead to obsessive thoughts (e.g., What if I drop the baby and hit their head? What if the baby stops breathing while sleeping?) or compulsive behaviors (e.g., repeatedly checking that the baby is breathing throughout the night or excessive cleaning and sterilizing of baby items) or a combination of both (Branquinho et al., 2022; Werner et al., 2015). PPD can also cause heightened irritability, frustration, and even anger, which may be directed toward oneself, one's partner, other family members, friends, and even the baby (Branquinho et al., 2022; Wells & Jeon, 2023). Sometimes, even minor stressors, such as sleep disruptions or trouble breastfeeding and switching to formula, may feel overwhelming and lead to easy agitation for the parent (Branquinho et al., 2022; Parry et al., 2023). These mood swings can strain relationships and contribute to feelings of guilt and isolation (Luciano et al., 2021). Furthermore, many individuals with PPD might feel that they do not meet societal expectations of how a parent "should" be, which can lead to a sense of failure, guilt, and shame (Dillon et al., 2022).

One of the key symptoms of PPD is difficulty establishing a strong emotional bond with the newborn. Parents with PPD may feel disconnected, indifferent, or even resentful toward their baby, making it challenging to establish a healthy parent-infant bond (Branquinho et al., 2022; Demirci & İnan, 2023; Wells et al., 2023). This emotional disconnection can stem from profound inadequacy, overwhelming fatigue, and depressive symptoms, all of which interfere with the parent's ability to respond sensitively to the baby's needs. As a result, parents may struggle to hold, comfort, or interact with their baby, hindering the development of secure attachment between parent and infant (Branquinho et al., 2022; Demirci & İnan, 2023; Wells et al., 2023). This early bonding process might have a detrimental impact on a child's attachment patterns later in life (Demirci & İnan, 2023; Werner et al., 2015).

Cognitive and Behavioral

Alongside emotional distress, PPD impacts cognitive function and behaviors. For example, it affects parents' ability to think clearly, make decisions, and engage in daily activities. These symptoms may reinforce feelings of inadequacy, isolation, and distress, making it more difficult for individuals to seek help or fulfill parental responsibilities (Branquinho et al., 2022). PPD is frequently associated with impairments in executive functioning, including thinking clearly, making decisions, and maintaining attention (Carlson et al., 2025; Vancappel et al., 2021). Thus, this cognitive impairment not only disrupts daily routines and tasks but also contributes to frustration and self-doubt. Parents with PPD may struggle and feel overwhelmed when making simple decisions and remembering important details, such as how to soothe their baby, which reinforces feelings of inadequacy and helplessness (Branquinho et al., 2022; Wells & Jeon, 2023).

Many individuals also experience rumination, wherein they fixate on perceived failures, doubts about their parenting abilities, or irrational fears regarding their baby's safety (Branquinho et al., 2022). In some cases, catastrophic thinking emerges when minor parenting challenges, such as difficulty soothing a crying baby, are interpreted as signs of personal failure (Branquinho et al., 2022; Dillon et al., 2022; Werner et al., 2015). Some individuals may also encounter disturbing, intrusive thoughts about accidentally or intentionally harming their baby. While these thoughts do not indicate an actual desire or intent to act on them, they can be deeply distressing and lead to avoidant behaviors, such as refusing to be alone with the baby due to fear (Eddy et al., 2019; Scarff, 2019).

In more severe cases, suicidal thoughts or ideation may occur (Werner et al., 2015). These thoughts are often linked to overwhelming feelings of hopelessness, helplessness, isolation, and emotional pain that may accompany depression. Individuals may feel unable to cope with the immense pressures of parenthood (e.g., being the perfect parent), leading to feelings of worthlessness and a distorted perception of their ability to care for their child (Branquinho et al., 2022; Dillon et al., 2022). Suicidal thoughts in PPD may manifest in various ways, from thoughts of death to more detailed plans of self-harm or suicide (Dillon et al., 2022). The distress caused by these thoughts can lead to isolation, as individuals might feel ashamed or fearful of expressing their emotional pain (Branquinho et al., 2022; Dillon et al., 2022). It is important to note that suicidal ideation in PPD is a medical emergency that requires immediate intervention. Suicide is a leading cause of death in the prenatal period (from pregnancy to the first year postpartum), accounting for 20% of postpartum deaths (Chin et al., 2022).

The cognitive distress associated with PPD often translates into noticeable behavioral changes, including social withdrawal, avoidance of parental responsibilities, and self-neglect. Many parents struggle to complete daily activities, take care of basic hygiene, maintain their physical appearance, or engage in previously enjoyable activities. This loss of interest and pleasure in once-enjoyable activities is a symptom known as anhedonia (Branquinho et al., 2022; Demirci & İnan, 2023). As a result, parents may withdraw from hobbies, social interactions, and, in some cases, spending time and bonding with their baby. This isolation often stems from feelings of shame or the belief that they cannot explain their struggles to family and friends (Wells et al., 2023). This disengagement from enjoyable activities can contribute to feelings of isolation and emotional numbness (Branquinho et al., 2022). In severe cases, individuals may exhibit reckless or self-destructive behaviors, such as substance use, impulsive actions, or expressing frustration through aggression towards loved ones (Eddy et al., 2019).

Physical

While PPD is mainly associated with emotional and psychological distress, it also manifests through physical symptoms that can impact daily functioning and overall well-being. These physical symptoms are often overlooked or attributed to the everyday demands of new parenthood, making it difficult for individuals to recognize that they may be experiencing PPD. However, persistent fatigue, sleep disturbances, changes in appetite, and various physical discomforts are key indicators that PPD extends beyond just emotional distress (American Psychiatric Association, 2022; Branquinho et al., 2022; Carlson et al., 2025; Luciano et al., 2021).

Extreme exhaustion is one of the most reported physical symptoms of PPD (Branquinho et al., 2022; Silang et al., 2024). It is natural for new parents to experience some fatigue due to disrupted sleep schedules. However, the fatigue associated with

PPD is more persistent and overwhelming and does not improve with rest (Branquinho et al., 2022). Despite extreme fatigue, many individuals with PPD find it difficult to fall or stay asleep due to racing thoughts, excessive worry about the baby, or feelings of anxiety, which is also known as insomnia (Werner et al., 2015). On the other hand, some might experience hypersomnia, characterized by excessive sleepiness and a struggle to get out of bed, feeling emotionally and physically unmotivated (Luciano et al., 2021). This bidirectional relationship between sleep disturbance and PPD creates a vicious cycle where poor sleep worsens depressive symptoms and depressive symptoms disrupt sleep (Dillon et al., 2022; Silang et al., 2024).

PPD can also impact eating habits, leading to noticeable weight changes. Some individuals experience a decreased desire to eat, possibly because food seems unimportant or unappealing, which can result in weight loss (Branquinho et al., 2022). On the other hand, some people might experience an increased appetite that can lead to compulsive eating behaviors as a way of self-soothing or coping with overwhelming emotions, which can result in unhealthy weight gain (Werner et al., 2015). Fluctuations in weight and appetite can also lead to other physiological symptoms, such as a weakened immune system and decreased energy levels.

During the postpartum period, hormonal shifts occur, with increased levels of estrogen and cortisol. When these hormones remain elevated for extended periods, they can impact mood stability and cause physical discomfort (Scarff, 2019). Furthermore, these hormonal changes may decrease libido. In some instances, individuals with PPD also report a diminished sexual desire and experience pain or discomfort during intercourse (Branquinho et al., 2022; Demirci & İnan, 2023).

PPD in Men

Although PPD is commonly associated with mothers, fathers can also experience it. PPD in men is often referred to as paternal PPD. Paternal PPD remains underdiagnosed and undertreated, mainly due to societal stigma and differences in symptom expression between men and women (Demirci & İnan, 2023; Dillon et al., 2022). Paternal PPD arises from a complex interplay of biological, psychological, and social factors similar to maternal PPD, but it has a unique gender-specific influence.

Fathers also experience hormonal shifts after childbirth, which include decreased testosterone levels along with increased estrogen and cortisol levels (Scarff, 2019). These hormonal fluctuations aim to foster paternal caregiving behaviors; however, they may also contribute to mood disturbances and depressive symptoms (Demirci & İnan, 2023; Scarff, 2019). Fathers might also face increased pressure to financially, emotionally, and physically provide for their family. At times, this pressure, combined with sleep deprivation and the adjustment to a new lifestyle, raises fathers' stress levels, making them more vulnerable to depression (Dillon et al., 2022; Malik, 2025). Men whose partners experience PPD are 2.5 times more likely to develop depression themselves because the emotional strain of supporting a partner and adapting to fatherhood can be overwhelming (Eddy et al., 2019; Wang et al., 2021). Fathers rarely receive the same level of emotional support or recognition of their struggles as mothers with PPD (Wells & Jeon, 2023). This lack of social and emotional support may heighten feelings of isolation, neglect, or inadequacy for fatherhood (Dillon et al., 2022).

Symptoms of paternal PPD differ slightly from those of maternal PPD. Paternal PPD is often expressed through externalized symptoms, such as anger towards others. Fathers with PPD frequently experience increased frustration, mood swings, and anger directed at their partner, child, or themselves (Demirci & İnan, 2023). Many fathers cope with depression by emotionally distancing themselves from their partner, baby, and social circles. Apathy, lack of enthusiasm, and disengagement from family life are key signs of paternal PPD (Malik, 2025). Another way for fathers to cope with depression is through substance use and/or working excessive hours that exceed workplace or financial requirements (i.e., workaholism). Fathers with PPD may engage in unhealthy coping mechanisms, such as excessive alcohol consumption or gambling, to manage emotional distress (Eddy et al., 2019; Scarff, 2019). Some fathers may also immerse themselves in work or hobbies to escape household and parenting responsibilities instead of expressing their feelings or seeking help (Wells & Jeon, 2023).

Treatment

PPD requires an individualized treatment plan to address its emotional, cognitive, and physiological dimensions. Treatments most often combine pharmacological and psychotherapeutic interventions. Treatment plans depend on the severity of the symptoms and the parents' personal and medical circumstances, including whether the mother is breastfeeding (Werner et al., 2015).

Pharmacological Interventions

When depressive symptoms are more severe and persistent, antidepressant medication becomes part of the treatment (Werner et al., 2015). The most commonly prescribed medications for PPD are selective serotonin reuptake inhibitors (SSRIs) due to their safety and tolerability profiles (Carlson et al., 2025). However, the use of medication treatments must be assessed carefully

when individuals are breastfeeding. Many mothers worry that medications, especially antidepressants, can be transferred into breast milk in small amounts, potentially exposing the infant to medication. However, this exposure is relatively low with SSRIs, making them safe to use while breastfeeding (Carlson et al., 2025; Werner et al., 2015). Still, clinicians need to weigh the risk-benefit ratio for both mother and child before prescribing any medicine. When PPD goes untreated, it creates significant risks to both parents' health and infant development, including insecure attachment, developmental delays, and behavioral problems later on (Demirci & İnan, 2023; Wells et al., 2023; Werner et al., 2015). Thus, adequate treatment, even if it involves medication, is necessary to restore maternal functioning and support healthy outcomes for parents and children.

Psychotherapeutic Interventions

Cognitive behavioral therapy (CBT) and interpersonal therapy (IPT) are regarded as the first-line psychotherapeutic treatments for mild to moderate cases of PDD (Branquinho et al., 2022; Dillon et al., 2022; Scarff, 2019; Werner et al., 2015). These treatment options are preferred by breastfeeding mothers (Scarff, 2019). Both CBT and IPT are evidence-based approaches that help alleviate depressive symptoms. CBT places a greater emphasis on individuals' distorted thought patterns, aiding them in recognizing and reframing these thoughts (Branquinho et al., 2022; Silang et al., 2024). In contrast, IPT focuses on enhancing interpersonal functioning and navigating role transitions related to parenthood (Scarff, 2019; Werner et al., 2015).

Additionally, new treatment methods for PPD are being explored, like light therapy. Light therapy helps with depressive symptoms by shifting melatonin rhythms (Parry et al., 2023). The bright side of light therapy is that it can be administered at home and has been shown to improve mood within two weeks (Parry et al., 2023). This intervention can provide an alternative, especially for individuals with sleep problems.

Moreover, psychoeducation, family therapy, and peer support groups can help reduce isolation and enhance a sense of connectedness (Eddy et al., 2019; Werner et al., 2015). Most of these peer support groups are online, including blogs, forums, and chat rooms (Eddy et al., 2019). These peer support groups are especially popular among younger parents, especially among new fathers (Eddy et al., 2019).

Conclusion

Postpartum depression is a serious mental health condition that affects both mothers and fathers, having significant implications for family well-being. Despite its high prevalence, PPD is often underdiagnosed and undertreated, particularly in men. While childbirth typically brings overwhelming happiness and joy, every parent's life changes after delivery, and some individuals require more emotional support to adapt to their new roles as parents. The onset of mood swings, irritability, and anxiety, also called "baby blues," is a normal response to postpartum hormonal fluctuations, as well as the demands of caring for a newborn. These symptoms usually resolve within two weeks without any medical intervention. However, when these symptoms persist or intensify, it may indicate a progression to PPD. PPD is more serious and long-lasting than "baby blues," requiring clinical intervention. Although PPD is not regarded as a distinct disorder in the DSM-5-TR, it is recognized as a subtype of major depressive disorder with peripartum onset. It is frequently underdiagnosed due to societal stigma, unrealistic parenting ideals, and concerns about the safety of treatment during breastfeeding. Differentiating between PPD and the baby blues is crucial for early intervention and appropriate support.

The symptomatology of PPD spans emotional, cognitive, behavioral, and physical domains. Emotionally, affected individuals often experience persistent sadness, irritability, and emotional numbness, along with intense guilt, hopelessness, and feelings of inadequacy. The inability to form an emotional bond with the baby is particularly distressing and can lead to attachment disorders. Cognitively, PPD impairs executive functioning, such as memory, attention, and decision-making, while triggering excessive rumination and intrusive thoughts. These symptoms can escalate to suicidal ideation, which remains a leading cause of maternal mortality. Behavioral manifestations include social withdrawal, neglect of self-care, anhedonia, and, in some cases, self-destructive behaviors like substance abuse. Physical symptoms are equally disruptive and often overlooked; these include persistent fatigue, sleep disturbances (ranging from insomnia to hypersomnia), appetite fluctuations, and diminished libido. Hormonal imbalances may also result in pain during intercourse and sexual dysfunction, further exacerbating psychological distress.

PPD is not limited to mothers; fathers can also experience it, although their symptoms are often misattributed or overlooked. Paternal PPD frequently manifests through externalizing behaviors such as anger, irritability, and emotional withdrawal, which are compounded by factors like hormonal changes, financial stress, and the mother's mental health status. Men are more likely to turn to maladaptive coping mechanisms, such as alcohol abuse, overworking, or gambling. These gendered expressions contribute to the underdiagnosis of paternal depression, despite its significant impact on family dynamics and child development.

Treatment for PPD must be multifaceted and tailored to individual needs. Pharmacological approaches, particularly selective serotonin reuptake inhibitors (SSRIs), are effective but may raise concerns about breastfeeding safety, which can deter mothers from initiating or adhering to medication. Psychotherapeutic interventions such as cognitive behavioral therapy (CBT) and interpersonal therapy (IPT) have shown strong efficacy in addressing cognitive distortions and interpersonal stressors. Support groups and psychoeducation also play a crucial role in reducing stigma and promoting help-seeking behaviors. An interdisciplinary, patient-centered approach is essential, integrating medical, psychological, and social support to optimize outcomes. Early screening and timely intervention alleviate parental suffering, protect infant well-being, and enhance overall family functioning.

Taken together, postpartum depression is a multifaceted and underdiagnosed condition that affects both parents, mothers and fathers. Its multidimensional symptom profile varies across emotional, cognitive, behavioral, and physical domains, necessitating comprehensive and individualized treatment. Bridging the gap between awareness and intervention through education, stigma reduction, and routine screening is essential to mitigate the adverse effects of PPD. Recognizing PPD as a legitimate and serious health concern is vital for fostering resilient families and promoting long-term psychological well-being.

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