

Postpartum Depression

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ABSTRACT

Postpartum depression is an underdiagnosed and undertreated condition. Postpartum depression can be influenced by a variety of psychosocial stresses. Those with a history of serious depression and those who have had depression during previous pregnancies are at a higher risk of postpartum depression. Maternal depression left untreated can harm a child's development, mother-infant attachment, and increase the chance of anxiety or depression symptoms in children later in life. The treatment of postpartum depression is an essential component of good medical care. The obstetrician and paediatrician can both help with postpartum depression screening and treatment. All health care workers and nurse practitioners must be aware of specific signs and symptoms, appropriate screening procedures, and effective treatment in order to prevent negative outcomes linked with depression and its influence on children. This review covers the etiology, symptoms, treatment and consequences of postpartum depression.

Keywords: *Postpartum-depression, Etiology, Symptoms, Treatment*

Mental health is as significant as physical health specially during maternal sessions. Mental health has a strong association with health issues during pregnancy, child birth and the postpartum (WHO 2014). Measuring and achieving health and development goals are the global agenda for women's and children's, and adolescent health (United Nations Secretary-General 2015). Who has given an estimated report that from 2000 to 2012, women in reproductive age (15-49) are more prone to develop mental and behavioural disorders (WHO 2012). Even though diagnostic and statistical manual of mental disorders (DSM-5), doesn't recognise this psychosis distinctly, but it fills the criteria of brief psychotic disorder. DSM-5 also suggests to specify the onset is during pregnancy or within 4 weeks of postpartum (Monzon et al, 2014). Based on clinical experiences, some clinicians believe that the time frame for postpartum specifier should be around 6 months or more, and the episodes can be present beyond 4 weeks. Psychosis during the perinatal period occurs within the first four weeks of postpartum period (Monzon et al, 2014, Sit et al, 2006). Postpartum psychosis clinical features involve mood disturbances, agitation, disorganized behaviour and thought processes, insomnia, and psychotic symptoms may include delusions, hallucinations with the content of kids (Monzon et al, 2014). Depression during the puerperium is a severe mental health issue for women, and the results can be devastating.

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The family's well-being and the child's psychological development (Boyce et al., 1991). The “baby blues,” which affect the majority of new mothers, must be recognised from postpartum depression. Weeping, melancholy, impatience, anxiety, and bewilderment are common symptoms of this syndrome, which peak around the fourth day following delivery and fade by the tenth. The woman's capacity to function is not routinely harmed by this brief mood disorder (Wisner et al., 2002). Postpartum depression is a mood disorder experienced by new mothers. In the past this was neglected which left the mothers suffer in fear and confusion. If left untreated this will adversely affect the mother-infant relationship and consequently lead to long term emotional problems for the child (Beck, 2006).

Etiology

Depression, especially PPD, is influenced by steroid hormones (Bloch et al., 2003; Brummelte and Galea, 2010b). The levels of steroid and peptide hormones fluctuate considerably during pregnancy and postpartum, which could contribute to the aetiology of PPD (Bloch et al., 2003; Brummelte and Galea, 2010b). Estradiol, corticosterone, corticotropic releasing hormone (CRH), and oxytocin levels fluctuate in rodents and humans, however with different patterns and gestational durations. Progesterone levels in women are approximately 20 percent higher during pregnancy and remain elevated throughout the pregnancy, whereas estradiol levels in women are very high (200–300 percent higher) by week 20 of pregnancy and remain high throughout the rest of the pregnancy, and both of these steroid hormones drop with the placenta's expulsion (Brett and Baxendale, 2001). Estradiol, corticosterone, corticotropic releasing hormone (CRH), and oxytocin levels alter in rodents and humans, but in different ways. The variability of the disease is a key difficulty in studies on the aetiology of postpartum depression. Depression that appears one week after delivery may have a different aetiology than depression that appears three months after delivery or depression that began during pregnancy but remained into the postpartum period. Furthermore, an anxious and obsessional postpartum depression may have a different aetiology than an anergic postpartum depression. Some authors have postulated that postpartum depressions exist in two distinct categories: cases in which the index episode occurs in the postpartum, and cases in which the postpartum depression represents a recurrence of a previous nonpuerperal depression (Brummelte & Galea 2016). In comparison to the former, the latter group appears to have a higher risk of nonpuerperal recurrence, necessitating careful long-term monitoring. Other therapeutic implications, such as treatment outcome discrepancies between the two groups, are unknown. To our knowledge, no research have looked into biological factors that could help separate these two groups of postpartum depressive women. Postpartum depression can cause a lot of stress for the new mother and her family, and it can also affect the child's cognitive and emotional development. Furthermore, postpartum depression puts a woman at risk for future psychopathology, especially after multiple deliveries. Identification of etiologic variables is thus critical for a better knowledge of prevention and treatment options. With more researchers using standardised rating instruments (such as the Edinburgh Postnatal Depression Scale) and adhering to strict postpartum depression criteria, research into the aetiology of postpartum depression is likely to increase in the future years (Hendrick et al., 1998).

Symptoms of Postpartum Depression

The following symptoms last for at least two weeks

- Persistent low, sad, empty, or anxious mood.
- Feeling guilty, worthless, hapless, or helplessness.

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- Loss of interest or pleasure in activities.
- Difficulty in concentrating, remembering.
- Difficulty in making decisions
- Finding it hard to fall asleep, or oversleeping
- Trouble in bonding and forming emotional attachment with the new born.
- Constant doubts about the ability to take good care of the new born.
- Thoughts about harming oneself or the baby (ResearchGate).

Combinations of risk factors are likely to contribute to postpartum depression. Maternal prenatal depression or anxiety, history of depression, child care stress, poor marital or partner relationship, low social support, and life stress are the most identified predictors (Horowitz & Goodman, 2004).

Treatment and consequences

Postpartum depression (PPD) is a common complication of childbearing, and has increasingly been identified as a major public health problem. Untreated maternal depression has multiple potential negative effects on maternal-infant attachment and child development. Screening for depression in the perinatal period is feasible in multiple primary care or obstetric settings, and can help identify depressed mothers earlier. However, there are multiple barriers to appropriate treatment, including concerns about medication effects in breastfeeding infants (Fitelson et al., 2011). The lack of knowledge about postpartum depression or the acceptance of myths was a significant help-seeking barrier and rendered mothers unable to recognize the symptoms of depression. Significant health service barriers were identified. Women preferred to have “talking therapies” with someone who was non-judgmental rather than receive pharmacological interventions (Dennis et al., 2006). Treatment for postpartum depression depends on the severity of symptoms and the level of functional impairment. Mild depression may be addressed with psychosocial strategies, including peer support and nondirective counselling, and psychological therapy is recommended for moderate depression; pharmacotherapy (generally a selective serotonin reuptake inhibitor [SSRI] as first-line treatment) is recommended for severe depression, for lack of response to nondrug therapy, or in accordance with patient preference (Stewart & Vigod 2016). Most SSRIs pass into breast milk at a dose that is less than 10% of the maternal level and are generally considered to be compatible with breast-feeding of healthy, full-term infants. A postpartum depression treatment efficacy study showed both a mother-infant psychotherapy group and interpersonal psychotherapy to be superior to a waiting-list comparison group in reducing maternal depressive symptoms, improving mothers' perceptions of their infants' adaptability and reinforcement value, and increasing mothers' positive affect and Verbalization with their infants (Clark et al., 2003). Postpartum depression is a major health issue for many women from diverse cultures. While pharmacological interventions are an effective treatment for depression, mothers are often reluctant to take antidepressant medication due to concerns about breast milk transmission or potential side-effects. It is important that non-pharmacologic interventions be evaluated for use with postpartum women experiencing depressive symptomatology. Postpartum depression affects approximately 13% of all new mothers. Many women desire to try treatment options other than medication. Results from nine trials involving 956 women found that both psychosocial (e.g., peer support, non-directive counselling) and psychological (e.g., cognitive behavioural therapy and interpersonal psychotherapy) interventions appear to be effective in reducing symptoms of postpartum depression. The long-term benefits are unknown (Dennis & Hodnett 2007).

CONCLUSION

Because of the nature of PPD and new mothers' inclination to dismiss their sensations as something other than a treatable psychiatric disorder, family physicians appear to be crucial in the discovery and treatment of this condition. The opportunity to educate parents and monitor behavioural changes in moms is a tool that the primary care physician has at his disposal. Because of the high prevalence of PPD, all physicians who treat obstetric and paediatric patients should create a procedure for detecting depressive symptoms. In the postpartum phase, women with major risk factors will need to be monitored more attentively. If a woman satisfies the DSM-IV criteria for PPD, she should start with counselling and then move on to medication if necessary. It is critical, as with other affective illnesses, to utilise a high enough dose of antidepressants for a long enough period of time to achieve complete recovery.

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Conflict of Interest

The author(s) declared no conflict of interest.

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