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Post-Partum Depression: A Review

Pooja Saharan[1], Aparna Sehgal[2]

[1]Lecturer, Psychiatry Nursing, Maharishi Markandeshwar University, Mullana Ambala

[2]Clinical Instructor, Maharishi Markandeshwar University, Mullana Ambala

Abstract: ***The postpartum period represents one of the most important life stages in which the accurate detection and treatment of psychological distress is required. It is very common now a days. The prevalence of PPD is about 8-35% depending on the method used for evaluation. WWW and TPP are also effective as treatment interventions along with other psychotherapies and pharmacotherapy (especially some selected antidepressants).***

1. Introduction

Having a child is a time of biological, psychological, and social change in a woman's life. These changes can contribute to personal growth and happiness, but they may also predispose women to emotional distress. The postpartum period represents one of the most important life stages in which the accurate detection and treatment of psychological distress is required. It involves changes in relationships between couples and within families, and is commonly a cause of additional stress[1].

2. Prevalence

Postpartum depression is a serious mental health condition that affects an estimated 13% to 19% of women who have recently given birth. [1]

The prevalence, onset and duration of the three types of postpartum affective disorders are shown in Table 1.1 (Adapted from Nonacs & Cohen, 1998). Each of them shall be discussed briefly.

Table 1.1: Postpartum Affective Disorders: Summary of Onset, Duration & Treatment. [2]

Disorder	Prevalence	Onset	Duration
Blues	30 – 75%	Day 3 or 4	Hours to days
Postpartum Depression	10 – 15%	Within 12 months	Weeks – months
Puerperal Psychosis	0.1 – 0.2 %	Within 2 weeks	Weeks - months

According to the World Health Organization, depression is the leading cause of disability worldwide (World Health Organization, 2012). Beyond the distress and impairment experienced by women with depression during the postpartum period, research also indicates that postpartum depression has negative consequences for the children of depressed mothers. [3]
According to Milgrom et al. the prevalence of PPD is about 8-35% depending on the method used for evaluation. [4]

3. Definition

In the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), 11 PPD is defined as a current, or the most recent, episode of major depressive disorder (MDD) or of bipolar I or bipolar II disorder, if the episode has an onset within four weeks postpartum. [5]

Postpartum depression is characterized by loss of interest or pleasure, depressed mood, psychomotor agitation or retardation, fatigue/sleep disturbance, changes in appetite, feelings of inadequacy, worthlessness, or guilt, and decreased concentration, all of which can interfere with effective maternal functioning. [6]

Postpartum depression is characterized as a persistent low mood in new mothers, which is often accompanied by feelings of sadness, worthlessness, and/or hopelessness. Postpartum depression differs from the "baby blues," as the "baby blues" is a briefer period of emotional disturbance (including dysphoria, tearfulness, mood lability, trouble sleeping, irritability, and anxiety) that is experienced by up to 4 in 5 women within the first few days following childbirth and usually remits within 10 days. [7]

Currently, the Diagnostic and Statistical Manual for Mental Disorders-Fifth Edition (DSM-5) classifies depression with peripartum onset as beginning during pregnancy or within the first four weeks postpartum. [8]

In contrast to the current criteria, some researchers recommend that this time frame be extended in future revisions of these guides to account for episode onset within the first six months postpartum. Further, in spite of the current ICD and DSM-5 guidelines, many researchers use a time frame that ranges up to one year postpartum for onset of postpartum Depression. [9]

While postpartum depression can be brief and remit unexpectedly, approximately 30% of women in community samples who experience postpartum depression continue to be depressed up to two years postpartum and 50% of women from clinical samples continue to have major depression throughout, and in some cases beyond, the first year postpartum. Furthermore, the illness course can vary and chronic depression for these women may consist of stable mild depression, stable major depression, or recurrent episodes of major depression without full remission between episodes. [10]

Clinical Features and Diagnostic criteria (DSM-IV)
Postpartum depression usually begins within 1–12 months after delivery. In some women, post partum blues simply continue and become more severe. In others, a period of wellbeing after delivery is followed by a gradual onset of

depression. The patterns of symptoms in women with postpartum depression are similar to those in women who have depression unrelated to childbirth. [11]

Postpartum depression shares the DSM-IV criteria for Major Depressive Disorder.

DSM-IV Criteria for Postpartum Depression

Five or more of the following symptoms, including:
- Depressed mood
- Markedly diminished interest or pleasure in activities
- Appetite disturbance
- Sleep disturbance
- Physical agitation or psychomotor retardation
- Fatigue, decreased energy
- Feelings of worthlessness or inappropriate guilt
- Decreased concentration or inability to make decisions
- Recurrent thoughts of death or suicidal ideation

Symptoms present most of the day, nearly every day, for 2 weeks and must represent a change from previous functioning causing significant distress or impairment. [12]

Depressive symptoms, including lack of energy and capacity to concentrate, may impair a woman's ability to be involved in her child's physical care and play, and may increase her level of irritability and self-preoccupation, resulting in an inability to meet her child's normal needs for attention. In addition, mothers who are depressed may experience a lack of affection toward their child, which can lead to feelings of guilt or worthlessness, and they may often feel anxious about doing psychological or physical harm toward their child.[13]

Studies have shown more insecure attachments, with disorganized-disoriented attachments being 3-4 times more likely in children of depressed mothers compared to children whose mothers were not depressed.[14]

Infants of women with postpartum depression have been observed to display more negative affect both with their mother and other non-depressed adults, including increased sober, sad, and/or flat affect and more protest behaviors.[15]

Postpartum depression is characterized by other symptoms like tearfulness, despondency, emotional lability, feelings of guilt, loss of appetite, and sleep disturbances as well as feelings of being inadequate and unable to cope with the infant, poor concentration and memory, fatigue and irritability.[16]

Screening tool (EPDS)
One of the most common self-report screening instruments used for postpartum depression is the **Edinburgh Postnatal Depression Scale (EPDS)**. (See Table 2.)[17]

Postpartum depression is the most common complication of childbearing. This 10-question self-rating scale has been proven to be an efficient and effective way of identifying patients at risk for "perinatal" depression. While this test was specifically designed for women who are pregnant or have just had a baby, it has also been shown to be an effective measure for general depression in the larger population.[17]

Due to findings that women with postpartum depression often have a high level of co-morbid anxiety, it is important that a postpartum depression screener also include anxiety items. The EPDS has a cutoff of 10 to signify probable depression, and has been shown to have a sensitivity of 95% and specificity of 93%.[18]

Treatment

Psychotherapy:
First line therapy is psychotherapy. Two therapies that have been shown to be beneficial are Interpersonal therapy (IPT) and short-term cognitive behavior therapy (CBT).

Interpersonal Therapy:
IPT, like CBT, has been effective with postpartum depression, although again most of the comparisons have been made with treatment as usual groups. In one study, for example, 205 pregnant women were randomized to either an interpersonal therapy group or a treatment as usual group. At 6 months the overall depression rate in the interpersonal therapy group was lower (16%) than in the control group (31%).[19]

Cognitive Behavior Therapy:
CBT has also been notably effective for women with postpartum depression. For example, in one study two groups of mothers were recruited at 2 days postpartum including one high risk group (high EPDS score) and one low risk group (low EPDS score). The high risk group went through CBT and the low risk group did not. At 12 months the low risk group who did not have CBT had higher EPDS scores.[20]

Mother–infant psychodynamic psychotherapy (PPT), **Watch, Wait, Wonder (WWW)**[21] and **toddler–parent psychotherapy (TPP)** are based on psychodynamic principles, where the mother is encouraged to understand the influence of prior relationships on her current relationship with her infant.

WWW[22] and TPP additionally incorporate attachment theory, where mothers are provided with guidance through specific instructions focused on increasing their responsiveness and sensitivity, as well as decreasing their intrusiveness. Thus, the mother empowers the infant to work through core relational struggles directly with her, providing a sense of efficacy and mastery within their interactions. These approaches result in improvement of maternal symptoms of depression, competence in the parenting role, greater reciprocity and decreased maternal intrusiveness in interactions.[21]

For Family Members:
Goodman asserts the need for the assessment of other family members. Partners can provide useful information in assessing for and treating PPD, but should also be viewed as potential targets for intervention. Other children should be screened for current symptoms of mental health issues and for vulnerabilities for developing them later, such as affect

regulation, stress reactivity and social and cognitive skills. Patterns of interactions between family members may be contributing to or maintaining the mother's depression, and it may be appropriate to refer a mother and her family to a family therapist.[24]

Pharmacotherapy

Women who receive a postpartum depression diagnosis may be treated with antidepressant drugs if their symptoms are considered moderate to severe (they are not for example prescribed to women with temporary baby blues). There are two main types of antidepressants commonly prescribed, these are: Selective Serotonin Reuptake Inhibitors (SSRIs) and Tricyclics (TCAs). SSRIs are a newer type of drug and studies show that women with postpartum depression respond better to them than TCAs. If they don't respond, then they can be switched to TCAs as a backup.

In a qualitative systematic review of randomized clinical trials comparing SSRIs to placebo and/or other treatments, six randomized clinical trials comprising 595 women met inclusion criteria. The treatment comparison groups included psychodynamic therapy, cognitive behaviour therapy, a tricyclic antidepressant and a placebo group. In all studies higher response and remission rates were noted for those treated with SSRIs.

Home-based interventions

Several home-based approaches are similar to mother–infant psychotherapy in that they address PPD at individual and interactional levels, considering the mother, the infant and the relationship in treatment. These approaches additionally recognize the ecological risk factors associated with poverty, such as accessibility and cost.

Home-based programmes that have provided a focus on increasing use of public resources, improving mother–infant interactions, decreasing social isolation of the mother and emphasizing the mother's role as a source of emotional security for the infant have resulted in improved cognitive and attachment functioning.[25]

4. Conclusion

Because of the prevalence of PPD, all the health care workers who care for mothers with PPD and children as well should develop a method for screening depressive symptoms. WWW and TPP are also effective as treatment interventions along with other psychotherapies and pharmacotherapy (especially some selected antidepressants).

5. Conflict of Interest

The author declares no conflict of interest.

Table No. 2 Edinburgh Postnatal Depression Scale (EPDS)

Please select the answer that comes closest to how you have felt in the past 7 days:

1 I have been able to laugh and see the funny side of things.
- As much as I always could
- Not quite so much now
- Definitely not so much now
- Not at all

2. I have looked forward with enjoyment to things.
- As much as I ever did
- Rather less than I used to
- Definitely less than I used to
- Hardly at all

3. I have blamed myself unnecessarily when things went wrong.
- Yes, most of the time
- Yes, some of the time
- Not very often
- No, never

4. I have been anxious or worried for no good reason.
- No not at all
- Hardly ever
- Yes, sometimes
- Yes, very often

5. I have felt scared or panicky for no very good reason.
- Yes, quite a lot
- Yes, sometimes
- No, not much
- No, not at all

6. Things have been getting on top of me.
- Yes, most of the time I haven't been able to cope at all
- Yes, sometimes I haven't been coping as well as usual
- No, most of the time I have coped quite well
- No, I have been coping as well as ever

7. I have been so unhappy that I have had difficulty sleeping.
- Yes, most of the time
- Yes, sometimes
- Not very often
- No, not at all

8. I have felt sad or miserable.
   - Yes, most of the time
   - Yes, sometimes
   - Not very often
   - No, not at all
9. I have been so unhappy that I have been crying.
   - Yes, most of the time
   - Yes, quite often
   - Only occasionally
   - No, never
10. The thought of harming myself has occurred to me.
   - Yes, quite often
   - Sometimes
   - Hardly ever
   - Never

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