

Understanding Postpartum Depression: A Theoretical Perspective

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Abstract

Postpartum depression is one of the public concerns for health practitioners affecting 40% women's. Biopsychosocial reasons contributing to risk of depression & affecting their mental health, parenting style and costing various domains of their life. Risk factors assessed regarding chances of having PPD are low socio-economic status, lack of social support, marital strained relations, past history of depression. This not only adversely affects the women but to infant, other children, spouse also. These affects her in interpersonal relation and continues to affect their life in long term. This emphasizes the importance of intervention in terms of psycho education, cognitive behavior therapy, interpersonal relationship, professional visit program. This paper will focus on understanding the postpartum depression, etiology, predictors and consequences with psychological intervention and its need.

Keywords: Postpartum depression, perinatal depression, biopsychosocial model, risk factors, prevalence

Motherhood is an epitome of love and happiness and brings with it a feeling of being blessed. While this new beginning promises to bring joyful moments to every mother but there is a flip side to it too. Baby blues are experienced by more than 40% mothers. This emotional state consists of tiredness, exhaustion, tension, unhappiness, stress about constant fear of rearing child leading into self-doubt and sadness. This disorder signifies a disruption of the relationship between mother and infant. This picture commonly disappears within a few days or weeks of delivery, but if it persists for more than two weeks, it leads to postpartum depression.

DSM-5 does not include postpartum depression as an independent criterion of diagnosis, however if symptoms of major depressive disorder are

seen within 4 weeks of post-delivery period, then it is considered to be postpartum depression. Diagnostic criteria in this case includes: (five or more symptoms out of 09 lasting for a period of two weeks) low mood, not interested in any desirable activities, disturbances in sleep and appetite, increase fatigability, lack of concentration, suicidal intent, feeling of worthlessness. The patient may also report significant disturbances in personal, social and occupational functioning which cannot be attributed to any medical reason or due to substance abuse; additionally there should not be any psychotic or manic/ hypo-manic conditions.

Depression in this phase of childbearing is a major concern for public health because of its complications and also due to various events related to biopsychosocial changes, leading to psychiatric illness and vulnerability to predisposing genetic and psychosocial factors.

Epidemiology of Postpartum Depression

In Australia, the United States and United Kingdom, reports of the prevalence of PPD vary between 7% to 20%., with the majority of studies indicating rates as high as 10% to 15%. (Gavin et al, 2005). while, in India prevalence rate for Postpartum depression is 22% approximate (Upadhyay et al, 2017). Pregnancy anxiety, stressful life events experienced during pregnancy or in the early puerperium, a lack of social or partner support, lack of a good socio-economic status, and having obstetric complications are all significant risk factors for PPD (O'Hara & Swaim, 1996). Researches are suggestive of the fact that depression after pregnancy may be more common and severe for mothers and their children in nations with modest incomes where availability of basic nutritional value and healthcare is uneven, mental health is typically not addressed as an issue in these situations (Milgram et al., 2008). Data from countries with limited resources reports that mothers of young babies' experience symptoms of depression that are higher than 25%, and in some situations may even reach 60%. According to a study conducted in Goa, India, having a female baby and experiencing economic difficulty or domestic abuse increases the likelihood of postpartum depression. These results imply that the interaction of socio-economic, interpersonal, and cultural factors may potentially substantially raise the risk of PPD (Patel et al., 2002).

Adversities faced by Depressed Mothers

When we leave depression unrecognized and treated, it is often associated with serious health consequences for the mother, her child, and the

family as a whole. When cultural or individual views of motherhood as an incredibly joyful, if exhausting, experience clash with the depressed woman's ability to feel fulfilled in her role as a mother, connection with her child, or handle the frequently exhausting tasks associated with caring for a newborn, PPD subjects women to a great deal of pain (Logsdon et al., 2006). In comparison to mothers who are not depressed, women with PPD are more likely to indulge in behaviors like smoking, alcohol consumption, substance abuse, and have either had or are currently experiencing physical, emotional, or sexual abuse. Research has also been conducted showcasing the detrimental effects of maternal depression on child outcomes (Whitaker et al., 2007). Depression greatly reduces a mother's ability to have a healthy relationship with her child. Studies have found that depressed women are more likely to engage in aggressive, unpleasant, or disengaged parenting practices and are less sensitive to newborn baby's cues (Murray et al., 1996). These problems in the mother-infant relationship are seen throughout cultural and monetary boundaries and have been connected to children's suboptimal cognitive development and adverse emotional growth. Other parenting behaviors are also affected along the way, such as poor sleep habits, unsafe safety practices, and less effective use of preventative healthcare. Behavioral problems and subsequent psychopathology, such as anxiety, disruption, and affective disorders, are more likely to afflict children of mothers who experience chronic depression. The psychiatric diagnoses of a mother's child, on the other hand, are less likely to alter or disappear when the mother experiences a remission from her depression. Negative child feeding outcomes, such as lower success rate of initiating and maintaining breastfeeding, lack of breastfeeding self-efficacy, and more challenges when breastfeeding, are also more common in mothers who are depressed. Maternal depression has also been linked to inadequate nutrition and a greater rate of diarrheal illness in children in low-income countries (Oberlander et al., 2007).

Causes

Postpartum depression is caused due to multiple reasons Viz Psychological, obstetric complications, biological, socio-environmental and lifestyle factors. Various studies have shown high correlation between history of any psychiatric illness like anxiety, depression during pregnancy and increased risk of postpartum depression due to high probability of hormonal imbalances (Davey et al., 2011).

Obstetric factors such as complicated pregnancy, last moment emergencies in labor room, birth by cesarean section, problems in breast feeding

etc. are all linked to high chances of PPD (Gaillard *et al.*, 2014).

Many a times, expectations of a smooth pregnancy and post pregnancy period may not be met. This may involve negative experiences like insomnia, not being able to carry out normal activities like socializing, traveling, being under rest due to major changes in daily routine post-delivery to name a few. All these may hamper the bond between the mother and child and further negatively impact their relationship (Figueiredo *et al.*, 2014).

Biological factors which are linked to high chances of PPD are: Motherhood at a young age (Milgrom *et al.*, 2008). Disorders of glucose metabolism, changes in the serotonin receptors & tryptophan due to deficiency of nutrients, reduced consumption of food enriched in protein (Aishwarya *et al.* 2013), Oxytocin plays a vital role in regulation of emotions when oxytocin induces activity of serotonin receptors it leads into feeling stressed (Yoshida *et al.*, 2009). Changes and fluctuations in Estrogen lead into depression (Douma *et al.*, 2005), Corticotrophin, thyroid dysfunction, cytokine and inflammatory responses, increased apoptosis T cells leads into changes in sleep, appetite, behavior, fatigability, temperament, mood swings (Miller, 2010).

Socio environmental factors predicting chances of postpartum depressions include: Lack of social support, Financial instability and Unemployment (Chien *et al.*, 2012), Interpersonal problems with spouse (Feng, Jones *et al.*, 2015), Sexual & verbal abuse, Domestic violence, Drinking or smoking behavior (Gurber *et al.*, 2017).

Lifestyle factors linked with postpartum depression are: Unhealthy food habits, changes in glucose metabolism, Sleep deprivation (Chang *et al.*, 2010), Lack of Social Interaction, Poor quality of life, Reduction in vitamin B6, B2, Intake of Zinc & selenium results into incidence of PPD (Ellsworth-Bowers *et al.*, 2012).

Predictors & consequences

A postpartum depression not only affects women, but has profound effect on infant, spouse, & other child. In context for children they face problem in areas of emotional, cognitive, behavioral, social competence (Carter, 2001) spouse of women undergoing depression undergo disturbances in their relationship & life, uncertain regarding their future, fear & prone to mental health disturbances (Zelkowitz, 2001). Older children face prob-

lem as mother face challenges in dealing with more than one child, hence pushed away & also face responsibilities of their siblings & mother with illness (Meighan,1999).

Significant predictors found out by Beck for PPD are prenatal depression, daily hassles, couple relationship, past episodes of depression, burden of childrearing, neonate behaviour and temperament, forced or unwanted conception, socio economic status, anxiety during prenatal period, marital status, pregnancy blues (Beck, 2001).

Psychosocial & history of mental wellbeing were studied in systematic reviews, strongest contributory factors to postpartum depression were anxiety, depression, stress, happenings during pregnancy, lack of support (Robertson et al., 2004)

Because of the long term consequences and its wide potential for devastating results, the necessity to intervene and prevent PPD becomes a major concern for health. Further awareness & contact with professionals during peri-natal phase gives a better opportunity for intervention & prevention.

Management and Intervention

Implementing Regular exercises and healthy eating habits play a vital role in reducing 50% chances of PPD (Chatzi *et al.*, 2011).

Regular exercise and walk comes with medicinal benefits and reduce risk of depression as they increase endogenous opioids and endorphins, which have positive impact on the mental well being. In addition, they enhance concentration and problem solving skills (Dinas et al., 2011).

Psychological interventions in combination with pharmacological treatment predict a better outcome. Psychological and other intervention includes psycho education which helps in awareness about the nature and course of illness and promotes coping and problem solving skills. A stronger social support network enhances interpersonal communication, deals with distortive cognitive patterns and increase sense of self efficacy (Appleby et al., 1997).

Women who are prone to depression need to be assessed and provided with psychological treatment to curb the risk factor associated with psychosocial reasons. The mechanism on which these intervention works are:

- Dealing with feeling of being alone & aloof
- Promoting healthy thoughts & behavior; decreasing dysfunctional thinking pattern
- Providing positive mental states
- Providing awareness in regard to accessibility of medical health services.

Stress can be dealt with and decreased through strategies like:

- Addressing the potential for risk issued by these hassles
- Providing various ways of coping, inculcating skills to cope & solve problems
- Promoting adaptive behavior

Pharmacological Treatments

Antidepressant medication

According to a small but rising body of studies, postpartum depression can be effectively treated with antidepressants. Despite the lack of data comparing the effectiveness of pharmaceuticals with other PPD treatment methods, effect size data indicate that drugs are at least as successful as most psychological interventions (Pearlstein, 2004). Several open trials have suggested that the antidepressants sertraline, venlafaxine, nefazodone, fluvoxamine, and bupropion may be effective in treating postpartum depression. Though limitations of these studies included that they lacked control groups, had tiny sample sizes of 4 to 15, and in some cases, were funded by the pharmaceutical companies that were responsible for the studied drugs (Nonacs, 2005).

Breastfeeding considerations

The World Health Organization, the American Academy of Pediatrics, and the American Academy of Family Physicians all suggest that mothers should themselves feed milk to their child for at least the first six months due to the advantages that have been thoroughly documented (The optimal duration of exclusive breastfeeding: report of expert consultation, 2002). There have been reports of potential minor to severe side effects

in newborns of antidepressant-using breastfeeding mothers, including disturbed sleep, gastrointestinal problems, respiratory problems, and seizures. Most frequently, modest side effects have been observed, and they have disappeared with drug discontinuation or breastfeeding.

Hormone therapy

The significant drop in the levels of estrogen and progesterone in the mother's body at the time of delivery has been hypothesized to be one factor in the initial development of PPD. Only a few of estrogen's effects on the brain include stimulation of neuronal development and survival, boosting of neurotransmitter function, reduction of oxidative stress, and modification of the hypothyseal-pituitary axis. A history of postpartum depression in women was indicative of disruptive moods when estradiol and progesterone levels dropped as opposed to in women without PPD. This was found in studies designed to mimic the hormonal alterations that take place just before childbirth.

Other Non-pharmacologic Treatments

There are several issues with pharmaceutical treatment, such as the impact on nursing, accessibility to care, the stigma associated with treating mental illness, its ineffectiveness, or one's own personal convictions. As a result, many women with PPD and their medical professionals may search for complementary therapies in addition to regular psychotherapy or medication.

Electroconvulsive Therapy

When anti-depressants fail to show visible results with PPD women or in women with high intensity psychosis, Electroconvulsive therapy (ECT) becomes a treatment option. There is little data that are particular to this group (Forray & Ostroff, 2007).

Bright Light Therapy

Bright light therapy was first used as a treatment method for seasonal affective disorder, though, research has shown that it is also helpful in treating nonseasonal depression. Given that the fetus or nursing baby exhibit no recognized dangers, light therapy offers a promising alternative for treating perinatal depression. However, there is inadequate evidence of its efficacy in the postpartum population, despite some positive early

findings in prenatal depression (Epperson, 2004).

Omega-3 Fatty Acids

Omega-3 fatty acids have attracted particular interest in the treatment of PPD due to their well-known health benefits for pregnant and postpartum women as well as some evidence indicating positive effects on mood in the general population (Freeman, 2006).

Acupuncture and Massage

Acupuncture involves the use of needles through insertion into various body parts in order to treat pathological processes and lessen discomfort. It is an old Chinese practice. It has had mixed reviews as a treatment option for people suffering from depression in the common people. However, it is being looked into more and more as adjuvant therapy for nausea, discomfort, breech presentation, and labor induction during pregnancy (Smith & Cochrane, 2009).

Psychological and Psychosocial Treatments

Reluctance to use anti-depressants in PPD mothers comes out of worry that their baby may consume the medicine through breast milk or that there may be adverse effects. Thus they frequently opt for psychosocial therapy.

Interpersonal therapy (IPT)

Interpersonal therapy (IPT) is a promising treatment for depression that focuses on repairing the interpersonal conflicts and the mood of the subject. IPT states that depression is a disorder of the social setting. The four interpersonal issue areas that the patient and clinician select as the therapeutic focus in IPT are role transition, role conflict, bereavement, or interpersonal difficulties. During the course of treatment (often 12–20 weeks), strategies are used so the patient can be assisted in modifying unhealthy relationship habits and building their social networks. Alterations have been made in IPT to treat postpartum depression-related concerns such the mother-child link, the spousal relationship, and the adjustment to returning to work.

Cognitive behavioral therapy (CBT)

The idea that perceptions and behaviors are closely correlated with mood serves as the cornerstone of cognitive behavioral therapy (CBT), a highly researched and effective procedure for severe depression. In order to improve distorted thought processes and adopt new behavioral patterns that improve coping and lessen discomfort, CBT focuses on assisting depressed people. Several studies have assessed CBT as a stand-alone therapy or in combination with other treatments for PPD. Appleby et al. used a factorial design to randomly assign 87 PPD women to one of four conditions in a randomized controlled psychotherapy-pharmacotherapy study. The conditions varied according to if the women received treatment with one to six sessions of CBT-based counseling or with fluoxetine or a placebo. Significant improvements were seen in depressive symptoms across all four therapy groups (Hollon, 1998).

Non-directive counseling

In contrast to IPT or CBT, psychosocial therapies are unstructured and non-manualized and may involve peer support and nondirective therapy. Nondirective therapy, commonly referred to as “person-centered” counseling, focuses on using supportive and empathetic listening. In the first substantial experiment assessing this strategy, Holden randomly assigned 50 PPD women to either eight weekly nondirective counseling sessions with a health visitor or normal medical care. In the UK, a health visitor is a public health nurse who visits pregnant and recently delivered mothers at home. According to this study, the percentage of PPD recovery for counseling (69%) was noticeably higher than the rate for the control group (38%) (Holden, 1989).

Peer and partner support enhancement

There is a possibility that therapies targeted at enhancing social support might be used as a form of treatment for perinatal depression because epidemiologic data and certain prospective studies consistently identify being socially isolated as a risk factor for postpartum depression. Few research has looked at how the partner or other family members might help with PPD recovery, even though lack of support by a significant other has been identified as a significant risk factor for PPD (Xie et al., 2009).

Conclusion

Postpartum Depression is affecting worldwide women irrespective of their region or status. With various contributing factor as hormonal

changes, genetic uploading, influenced by various psycho social factors such as, single mother, unwanted pregnancy, role confusion, low income & social support, these all make mothers vulnerable to PPD affecting their parenting style & various domains of their life in long term. The rising prevalence and consequences makes it more important for considering preventive strategies & psychological intervention. Awareness, dealing with the obstetric changes, social support, makes the pregnancy comfortable during & after delivery.

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