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POST PARTUM DEPRESSION AND ITS MANAGEMENT- A COMPREHEMSIVE REVIEW

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ABSTRACT
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. This Article reviews the literature and recommendations for the treatment of postpartum depression, With a focus on the range of pharmacological, psychotherapeutic, and other non-pharmacologic interventions.

KEYWORDS: Antidepressants, depression, Lactation, postpartum, psychotherapy screening, postnatal depression.

INTRODUCTION
Estimates of prevalence of PPD in the US, UK and Australia range from 7%–20%, With most studies suggesting rates between 10%–15%.6,7 Significant risk factors For PPD include a history of depression prior to or during pregnancy, anxiety during pregnancy, experiencing stressful life events during pregnancy or the early Puerperium, low levels of social support 8 Or partner support, Low socioeconomic Status, and obstetric complications. Although mental health often is not prioritized as a problem in poorer countries where access to basic nutrition and health care are not consistent, the evidence suggests that postnatal depression may be both more common and more grave for women and their children in low-income countries. The Limited data from resource-constrained countries suggests that rates of depression In mothers of young infants exceeds 25%, and in some settings may be as high as 60%. The intersection of cultural, interpersonal and socioeconomic factors may Also confer significant risk of PPD: in one study in Goa, India, risk for depression After delivery increased with economic deprivation, marital violence, and female Gender of the infant.[1]

Childbirth can trigger a variety of psychiatric illnesses Including mood disorders. The term "postpartum Mood disorders" generally refers to the baby blues, Postpartum depression, and puerperal psychosis. The baby Blues affect 30% to 75% of women shortly after childbirth, With symptoms of mood lability, tearfulness, anxiety, Insomnia, and irritability. Because of the mild and transient Nature of symptoms, no treatment is required; however, The blues may sometimes be the early manifestation of Postpartum depression or puerperal psychosis. Puerperal Psychosis, on the other hand, is a rare condition (1 in 500 To 1000 deliveries) but serious because of its association with maternal suicide and infanticide.[2]

Negative Effect Of Postpartum Depression
Untreated maternal depression is associated with serious morbidity for the mother, The infant, and the family system. Perinatal depression causes significant suffering in Women at a time when personal or societal notions of motherhood as a uniquely joyful, if tiring, experience may be incongruous with the depressed woman's ability to feel gratification in the mothering role, Connect with her infant or carry out the often overwhelming tasks of caring for a new baby. Such a disconnect can reinforce the disabling sense of isolation, guilt, helplessness and hopelessness that frequently characterize the depressed state.[3] Women with PPD are at higher risk for smoking, alcohol or illicit substance abuse, and are more likely than nondepressed mothers to experience current or recent physical, emotional, or sexual abuse. Although rates of suicide for women during pregnancy and the puerperum are Lower than the general population, suicide is an important cause of maternal mortality. Self-

inflicted injury is the Leading cause of one-year maternal mortality in the United Kingdom. A recent World Health Organization report on women's health identifies self-inflicted injury as the second leading cause of maternal mortality in high-income countries; suicide remains an important cause of maternal deaths in moderate and low-income countries. Intrusive Thoughts of accidental or intentional harm to the baby are common in the early postpartum time. These thoughts are more frequent and distressing in women with postpartum depression; however, nonpsychotic depressed women are unlikely to commit infanticide.[4]

Diagnosis of postpartum depression

The diagnostic criteria for a Major Depressive Episode (MDE) as defined by the Diagnostic and Statistical Manual (DSM-IV) do not differ in the postpartum period as compared to other times, and include at least 2 weeks of persistent Low mood or anhedonia, as well as at least four of the Following: increased or decreased appetite, sleep disturbance, Psychomotor agitation or retardation, low energy, feelings of worthlessness, low concentration, and suicidal ideation.[5]

A MDE may be classified as having a postpartum onset if the depressive symptoms begin within the first 4 weeks After delivery. However, studies suggest that depressive episodes are significantly more common in women in the first Three months after delivery, and an increased vulnerability To psychiatric illness may persist for a year or more. It is Important to differentiate PPD from other psychiatric and Nonpsychiatric diagnoses.[6] The "postpartum blues" or "baby Blues" is a transient mood disturbance that affects up to 75% Of new mothers in the 10 days following delivery, and consists of crying, irritability, fatigue, anxiety, and emotional lability. Symptoms are generally mild and self-limited, and do not Involve total loss of pleasure or interest, persistent low mood, Or suicidal ideation. On the other extreme, postpartum Psychosis is a psychiatric emergency that requires immediate Intervention, and is characterized by the rapid onset of severe Mood swings, a waxing and waning sensorium, delusions, Hallucinations or disorganized behaviours, and a relatively High incidence of suicidal ideation or homicidal ideation Toward the infant. Women presenting with a depressive episode, mood elevation, or psychotic symptoms should be screened for any prior history of mania or hypomania to Rule out previously undiagnosed bipolar disorder. Anxiety Disorders are common in perinatal women, and women may have depression comorbid with obsessive-compulsive symptoms, generalized anxiety disorder, panic disorder or Post-traumatic stress disorder. Substance use and medical Causes of psychiatric symptoms, such as thyroid disorders, should also be considered.[7]

Screening for postpartum depression

There has been increasing focus on the importance of Early and accurate detection and treatment of depression after or during pregnancy. Identification of depression In the postpartum period may be complicated by some Of the normal physical and emotional demands of new Motherhood, including changes in energy and appetite, sleep Deprivation, and Heightened concern for the infant. Experts have recommended screening for PPD at the first postnatal obstetrical visit (usually 4–6 weeks after delivery), or in the family practice40 or pediatric setting, as these are the most widespread points of interaction with the health care system for new mothers within the first three months of delivery.[8]

Clinical Presentation

Postpartum depression is usually defined as an episode of depression with an onset of symptoms during the First four weeks after delivery; however, women remain At risk for developing depression for several months following delivery. According to the DSM-IV diagnostic Criteria, the postpartum onset specifier can be applied to the current major depressive episode of major depressive disorder, bipolar I disorder, or bipolar II disorder.6 Some Women have a recurrence of depression after childbirth, While others experience first onset of depression in the Postpartum period.[9] The symptoms must be present Most of the day, nearly every day, for two weeks and there Must be an associated decline in social and/or occupational Functioning. A depressed mood caused by substances (such As drugs, alcohol, or medications) or which is part of a general Medical condition is not considered towards a diagnosis of a Major depressive episode. Further, it is important to rule out Uncomplicated bereavement. The symptoms of depression Are usually the same, whether experienced postpartum or not; however, there is often a focus on mothering or infant Care issues in postpartum depression.[10]

Pharmacological Treatments for Postpartum Depression

1. Antidepressant medication

A small but growing literature suggests that postpartum Depression can be thought of as a variant of major depression That responds similarly to antidepressant medication. Concerns unique to pharmacologic treatment of PPD include Metabolic changes in the postpartum period, exposure of the Infant to medication in breast milk, the effect of depression And treatment on the ability of the depressed mother to care for A new baby, and the perceived stigma of being seen as a "bad Mother" for requiring medication. These factors, as well as The woman's level of distress, access to care, and experience With past treatment may influence the decision of the patient And her caregiver regarding the choice of pharmacologic and Nonpharmacologic treatments for PPD. Data comparing the Effectiveness of medication against other treatment modalities For PPD are scarce, though do suggest that medications are at Least as effective as most psychological interventions based on Effect size. To date, four randomized controlled studies on The treatment of PPD with antidepressant

medications have Been published, along with several open trials. Additionally, Two randomized studies have looked at the prevention of PPD With antidepressant medication.[11]

Breastfeeding consideration

The benefits of breastfeeding have been well described and have led the World Health Organization, the American Academy of Pediatrics and the American Academy of Family Practitioners to recommend breastfeeding for at least The first 6 months for most women. Potential effects of Antidepressant medication on breastfeeding are of concern to Many mothers and clinicians. However, nonpharmacologic treatments are not effective for some women, and may not be accessible for many women.[12]

Hormone therapy

There is a dramatic drop in maternal levels of estrogen and progesterone at the time of delivery, and this shift Has been proposed as one trigger for the onset of PPD in Some women. Effects of estrogen in the brain include the Promotion of neuronal growth and survival, enhancement Of neurotransmitter activity, mitigation of oxidative stress and modulation of the hypophyseal-pituitary axis.[13]

In a double-blind placebo-controlled study by Gregoire et al women with postpartum depression were randomized to Receive estrogen or placebo patches. Breastfeeding women Were excluded. Over the first month of treatment, women Receiving estrogen showed greater and more rapid improvement. In their symptoms as measured on the Edinburgh Postnatal Depression Scale and in clinical interviews.[14] Women in the Placebo group also improved but maintained depression scores Above the screening threshold. Neither group had complete Remission of symptoms. The authors did not control for women Receiving concomitant antidepressant medication, which was more common in the estrogen treatment group, making interpretation of the study results difficult. Additionally, women Were included in the study up to 18 months postpartum, by which time the effects the postpartum drop in estrogen would likely have resolved.[15]

Psychological and psychosocial Treatments for postpartum depression

Many mothers with postpartum depression are hesitant to Take antidepressants due to concerns about infant exposure to medication through breast milk or concerns about potential Side effects, and therefore often prefer psychological Treatments. Although relatively few studies have Systematically investigated nonpharmacologic treatments for PPD, existing research supports the use of both psychological treatments (specifically interpersonal therapy, cognitive-behavioural therapy, and psychodynamic psychotherapy), as well as psychosocial interventions, such as nondirective counseling. A Cochrane meta-analysis of ten randomized controlled trials of psychosocial and psychological treatments for postpartum depression concluded that both psychosocial and psychological interventions are effective in decreasing depression and are viable treatment options for postpartum depression.[16]

Interpersonal therapy (IPT)

Interpersonal therapy (IPT) is a time-limited treatment for Major depression based on addressing the connection between Interpersonal problems and mood, which frames depression as a medical illness occurring in a social context. In IPT, the Patient and clinician select one of four interpersonal problem Areas (role transition, role dispute, grief, or interpersonal Deficits) as a treatment focus. Over the course of the therapy (typically 12–20 weeks), strategies are pursued to assist Patients in modifying problematic approaches to relationships and in building better social support. IPT has been adapted to address problem areas relevant to postpartum depression Such as the relationship between mother and infant, mother and partner, and transition back to work. The fact that IPT Is both time-limited and problem-focused fits well with the Demands of the postpartum mother.

Several studies, including one large-scale randomized Controlled trial, have supported the effectiveness of IPT For treating postpartum depression. O'Hara and colleagues Randomized 120 women with postpartum depression to receive 12 weekly 60-minute individual sessions of manualized IPT by a trained therapist versus control condition of a Wait-list. The women who received IPT had a significant Decrease in their depressive symptomatology (measured by Hamilton Depression Rating Scale and Beck Depression Inventory) as compared to the wait-list group, as well as Significant improvement in social adjustment scores. In Another study by Clark et al women with postpartum Depression were assigned to individual IPT (12 sessions) Versus mother–infant group therapy versus a wait-list Condition. Both IPT and mother–infant group therapy were associated with greater reduction in depressive symptoms as Compared to the wait-list conditions. Both studies support the Effectiveness of IPT as a treatment for PPD, though there is Not enough data to suggest a specific benefit to IPT compared With other therapeutic modalities.[17]

Cognitive behavioural therapy (CBT)

Cognitive behavioural therapy (CBT), a well-studied and effective treatment for major depression, is based on the premise That both perceptions and behaviour's are intimately linked to Mood. CBT focuses on helping depressed patients to modify Distorted patterns of negative thinking and to make behavioural Changes that enhance coping and reduce distress. There Have been several trials assessing CBT alone or with other Interventions for the treatment of PPD. In a randomized controlled psychotherapy-pharmacotherapy study, Appleby et al Assigned 87 women with PPD to one of four conditions in a Factorial design, varying based on

treatment with either one or Six sessions of CBT-based counseling, and treatment with fluoxetine or placebo. All four treatment groups had significant Improvement in depressive symptoms. Women who received Six CBT sessions versus one had greater decrease in depressive symptoms. Six sessions of CBT plus placebo pill was as effective as treatment with fluoxetine plus one session of CBT, but there was no added benefit in the group receiving 6 Counseling sessions in combination with fluoxetine. It should Be noted that the counseling sessions were delivered by Briefly trained non-specialists, and six sessions of CBT may Not be a sufficient representation of a standard course of Treatment. In another combination medication-CBT study, Misri et al randomized 35 women with PPD and comorbid Anxiety either to paroxetine monotherapy or paroxetine and 12 weekly manualized CBT session with physiologist.[18]

Nondirective counselling

As compared with IPT or CBT, psychosocial interventions are unstructured and non-manualized, and include nondirective counseling and peer support. nondirective counseling (also known as "person-centered") is based on the use of empathic and non-judgmental listening and support. In the first notable study evaluating this intervention, Holden randomized 50 Women with PPD to 8 weekly nondirective counseling sessions with a health visitor or routine primary care.[19] A health visitor in the UK is a public health nurse who conducts home Visits with pregnant and postpartum women. This study found that the rate of recovery from PPD for counseling (69%) was Significantly greater than that of the control group (38%). In a similar study conducted in Sweden, Wickberg and Hwang Randomized 31 women with PPD to receive six nondirective counseling sessions by child health clinic nurses or routine primary care. As in the Holden study, a significantly greater Percentage of women in the treatment group (80%) had remission of depression than in the control group (25%). Study Limitations include the removal of four study participants, Two in each group, for more intensive mental health services due to illness severity.[20]

Maintenance Treatment of Postpartum Depression

Women who are at risk for non-postpartum recurrences of Depression should be evaluated for maintenance treatment. The risk factors that support the need for maintenance Treatment are a history of recurrent episodes (3 or more), Chronic episodes, psychotic episodes, severe episodes, Episodes that are difficult to treat, significant comorbidity (psychiatric or medical), residual symptoms (lack of Remission) during the current episode, and a history of Recurrence during discontinuation of antidepressants.[21]

Exercise -Several studies have investigated the role that exercise can Play in alleviating postpartum depressive symptoms. A Study by Da Costa et al looked at 88 women with PPD who Were randomized to a 12-week, home-based exercise program or usual care. There was a reduction in depression Rating scales in the intervention group as compared to the Usual care group post-treatment, though not at the 3-month Follow-up.[22] However, Ko et al investigated a low-intensity Exercise program that was specifically designed and administered to women with postpartum fatigue and depression. There was no significant change in depression between the Treatment group and the control group. Despite the limited Evidence of efficacy for the treatment of PPD, the UK National Institute for Health and Clinical Excellence (NICE) Has recommended in their antenatal and postnatal mental Health guidelines that health professionals should consider Exercise as a management strategy in women experiencing Mild-to-moderate depression. A review of the effects of Exercise on PPD defined "feasible and effective" exercise As: moderate-intensity activities for at least 30 minutes per Day, five days of the week, including walking in the form of "pram pushing".[22]

CONCLUSION

Postpartum depression is a major international public health problem that affects at least 1 in 8 mothers and their children In the year after childbirth worldwide. PPD may be more Common and may be associated with more morbidity for both mothers and children in resource-poor countries. PPD has Been associated with significant negative effects not only on Depressed women themselves but on the physical, cognitive and emotional development of their children. Early detection and intervention are important in mitigating these risks.

Pregnant women with a history of postpartum depression or non-puerperal depression should be assessed regarding the need for preventive treatment of a recurrence of depression after childbirth. The available evidence suggests that antidepressants typically used to treat non-postpartum depression are Also effective in the acute, maintenance, and preventive Treatment of postpartum depression. Women with mild to moderate depression may benefit from psychotherapy, including cognitive behavioural therapy, interpersonal Therapy, psychodynamic psychotherapy, or non-directive counselling.

REFERENCE

1. P. Postnatal depression: a global public health perspective. Perspectives in Public Health, 2009; 129: 221227.
2. Wisner KL, Chambers C, Sit DKY. Postpartum depression: a major Public health problem. JAMA. 2006; 296: 26162618.
3. Marcus SM, Flynn HA, Blow FC, Barry K. Depressive symptoms among Pregnant women screened in obstetrics settings. J Womens Health, 2003; 12(4): 373–380.

4. Kelly R, Zatzick D, Anders T. The detection and treatment of psychiatric Disorders and substance use among pregnant women cared for in Obstetrics. Am J Psychiatry, 2001; 158: 213–219.
5. Abrams LS, Dornig K, Curran L. Barriers to service use for postpartum Depression symptoms among low-income ethnic minority mothers in The United States. Qual Health Res., 2009; 19(4): 535–551.
6. Gavin NI, Gaynes BN, Lohr KN, Meltzer-Brody S, Gartlehner G, Swinson T. Perinatal depression: a systematic review of prevalence And incidence. Obstetrics and Gynecology, 2005; 106(5): 1071–1083.
7. O'Hara MW, Swain AM. Rates and risk of postpartum depression: A meta-analysis. International Review of Psychiatry, 1996; 8: 37–54.
8. Robertson E, Grace S, Wallington T, Stewart D. Antenatal risk factors For postpartum depression: a synthesis of recent literature. Gen Hosp Psychiatry, 2004; 26: 289–295.
9. Milgrom J, Gemmill AW, Bilszta JL, et al. Antenatal risk factors for Postnatal depression: a large prospective study. J Affect Disord, 2008 May; 108(1–2): 147–157.
10. Department of Reproductive Health and Research, World Health Organization. Maternal mental health and child health and development in Resource-constrained settings: Report of a UNFPA/WHO international Expert meeting: the interface between reproductive health and mental Health, Hanoi, 2007 June 21–23. WHO Press, Geneva, 2009.
11. Halbreich U, Karkun S. Cross-cultural and social diversity of prevalence Of postpartum depression and depressive symptoms. Journal of Affective Disorders, 2006; 9197–9111.
12. Patel V, Rodrigues M, DeSouza N. Gender, poverty, and postnatal Depression: a study of mothers in Goa, India. Am J Psychiatry, 2002; 159: 43–47.
13. Logsdon MC, Wisner KL, Pinto-Foltz MD. The impact of postpartum Depression on mothering. J Obstetr Gynecol Neonat Nurs, 2006; 35: 652–658.
14. O'Hara MW. Postpartum depression: what we know. J Clin Psychology, 2009; 65(12): 1258–1269.
15. Whitaker RC, Orzol SM, Kahn RS. The co-occurrence of smoking and A major depressive episode among mothers 15 months after delivery. Prev Med, 2007; 45(6): 476–480.
16. Ross LE, Dennis CL. The prevalence of postpartum depression among Women with substance use, an abuse history, or chronic illness: a systematic review. J Womens Health, 2009; 18(4): 475–486.
17. World Health Organization. Women and health: today's evidence Tomorrow's agenda. Geneva: WHO Press, 2009.
18. Fair brother N, Woody SR. New mothers' thoughts of harm related to The new-born. Arch Womens Mental Health, 2008; 11(3): 221–229.
19. Jennings KD, Ross S, Popper S, Elmore M. Thoughts of harming infants in depressed and non-depressed mothers. J Affect Disord, 1999; 54(1–2): 21–28.
20. Sharma V, Khan M, Corpse C, Sharma, P. Missed bipolarity and Psychiatric comorbidity in women with postpartum depression. Bipolar Disord, 2008; 10: 742–7.
21. Mestman JH. Evaluating and managing postpartum thyroid dysfunction. Medscape Womens Health, 1997; 2: 3.
22. Albacar G, Sans T, Martín-Santos R, Garcia-Esteve L, Guillamat R, Sanjuan J, et al. An association between plasma ferritin concentrations Measured 48h after delivery and postpartum depression. J Affect Disord, 2011; 131: 136–42.