ISSN: 0973-0583

Postpartum Depression Common But Undiagnosed and Untreated Mental Disorder

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ABSTRACT

Postpartum depression is a condition that occurs in mother after childbirth. It is a unique and often unrecognized disorder, yet its impact can be devastating. This phenomenon affects women universally in countries around the world, making it the most common complication following childbirth, with 10%–15% of women experiencing it. If left untreated, maternal depression can lead to serious health issues for the mother, the infant, and the family as a whole. Moreover, when depression persists in mothers, it puts their children at a higher risk for behavioral problems and later psychopathology, including anxiety, disruptive, and affective disorders. It can be treated through a combination of psychological interventions such as cognitive behavior therapy, interpersonal therapy, and family therapy, along with medical interventions involving antidepressants. However, despite the availability of treatments, postpartum depression is often subject to stigma, similarly to other mental disorders. Unfortunately, this stigma, whether with or without support from family members and health professionals, can deter women from seeking help for their postpartum depression.

Keywords: Postpartum depression, Cognitive behaviour therapy, Interpersonal therapy, Supportive therapy, Family therapy, antidepressant and stigma

Introduction:

Postpartum depression, also known as postnatal depression, is a depressive disorder that may affect mothers following childbirth. This condition is observed universally, impacting women in countries around the globe. The prevalence of this distressing mental disorder ranges from 5% to 60.8% worldwide (Klainin & Arthur, 2009).

Postpartum depression is characterized as non-psychotic depressive episodes, marked by symptoms like loss of interest, insomnia, and decreased energy experienced by mothers within 4 to 6 weeks after delivery, as defined by the World Health Organization (WHO, 2001). The symptoms of postpartum depression, as described by the World Health Organization in 2003, encompass feelings of anxiety, hopelessness, decreased appetite, and difficulty concentrating, reduced interest in the baby or life in general, and altered sleep patterns (Segre & Davis, 2013).

In the immediate postpartum period, approximately 50-80% of women experience various mood disturbances, such as anxiety, heightened emotional sensitivity, feelings of loneliness, fear of unknown, and/or guilt. As time progress and the mother forms a strong bond with her new-born baby, these emotions usually decrease. however, a notable subset of women, comprising 10-15%, goes on to develop severe symptoms of depression or anxiety, which is called postpartum depression (Patel et al, 2015)

Postpartum psychiatric disorders can be categorized into three main types: postpartum blues,

postpartum psychosis, and postpartum depression. The "postpartum blues" or "baby blues" is a short-term mood disturbance that affects up to 75% of new mothers during the 10 days following childbirth. It is characterized by symptoms like crying, irritability, fatigue, anxiety, and emotional liability. Generally, these symptoms are mild and self-limited, and they do not involve a complete loss of pleasure or interest, persistent low mood, or thoughts of suicide (Beck, 2006).

On the opposite end of the spectrum, postpartum psychosis is a psychiatric emergency that demands immediate intervention. It is marked by a rapid onset of severe mood swings, fluctuating consciousness, delusions, hallucinations, or disorganized behaviors, and a relatively high incidence of thoughts of suicide or harm towards the infant (Sit et al., 2006). The Edinburgh Postnatal Depression Rating Scale is a commonly used tool for screening depression specifically related to the postpartum period. It aids in identifying and evaluating postpartum depression symptoms in new mothers.

Epidemiology:

Postpartum depression affects approximately 10-15% of all mothers in western societies. However, recent epidemiological studies have shown varying prevalence rates for postpartum depression across different regions: 15.8% in Arab women,16% in Zimbabwean women, 34.7% in South African women, 11.2% in Chinese women, 17% in Japanese women, and 23% in Goan women in India (Thomas et al., 2018). In India, the prevalence of postpartum depression ranges from 11% to 16% (Hegde et al., 2012).

Postpartum blues, with an incidence of 300 750 per 1000 mothers globally, typically resolve within a few days to a week, causing few negative effects and usually only requiring reassurance. On the other hand, postpartum psychosis, with a global prevalence ranging from 0.89 to 2.6 per 1000 births, is a severe disorder that manifests within four weeks postpartum and necessitates hospitalization. Postpartum depression can begin shortly after childbirth or continue from antenatal depression, and it requires appropriate treatment. The worldwide prevalence of postpartum depression has been estimated at 100 150 per 1000 births. Despite its significance as a health issue for many women, postpartum depression often goes undiagnosed and untreated (Upadhyay et al., 2017).

Postpartum Depression And Stigma:

Postpartum depression remains associated with significant stigma, which can complicate efforts to accurately determine its true prevalence. This stigma surrounding mental health, regardless of whether there is support from family members and health professionals, often acts as a deterrent for women seeking help for their postpartum depression. However, for those who do seek and receive medical assistance, some find the diagnosis beneficial and become advocates for raising awareness of postpartum depression within the health professional community (Halbreich & Karkun, 2006).

Etiology Of Postpartum Depression:

The development of postpartum disorders does not have a clear etiology and may arise from a combination of factors. Several factors are associated with an increased risk of postpartum depression. Genetic susceptibility and hormonal changes plays a role, influenced by various risk factors such as unplanned pregnancy, single parenthood, financial difficulties, stressful life events, child care-related stress, and having a congenitally malformed infant (Chandra, 2009). Hormones like estrogen, progesterone, thyroid hormone, testosterone, endorphins, and cortisol have been associated with this disorder. Additionally, the use of synthetic oxytocin, a drug used to induce labor, has been associated with increased rates of postpartum depression and anxiety (Kroll-Desrosiers et al., 2017).

Personal and family history of depression and the stress of caring for a new baby are also considered contributors to postpartum depression (Schiller et al., 2015; Kim et al., 2014). A history of depression and anxiety, along with reduced social support (emotional, financial, intelligence support, and empathy), experiencing the illness or death of a baby, substance abuse by the husband, complications during the current pregnancy, giving birth to a female baby, and lack of support from the husband are among the significant environmental factors linked to the onset of depression and anxiety disorders (Upadhyay et al., 2017).

Other factors that contribute to postpartum depression include the mother's marital status, an unplanned/unwanted pregnancy, the undesired gender of the baby, having a poor relationship with a partner, experiencing a lack of emotional support within the family, insufficient social support, poverty, and social adversity, previous personal history of depression, prenatal depression or anxiety, childcare stress, poor physical health of the woman or the baby, and chance adverse life events (Patel et al., 2002; Beck, 2001). In a study conducted in Goa, India, depression risk after delivery was found to be higher in cases of economic deprivation, marital violence, and having a female infant (Patel et al., 2002).

Effects Of Postpartum Depression:

Untreated maternal depression has severe repercussions for the well-being of the mother, the infant, and the family system. Numerous studies have highlighted the detrimental impact of prolonged and severe postnatal depression on relationships, families, and children. Such consequences include increased depression in partners, higher rates of divorce, weakened bonding with the infant, and reduced emotional adjustment and cognitive development among children (John, 2011).

Depression significantly impairs a mother's ability to interact appropriately with her child (Logsdon et al., 2006). Depressed women often exhibit diminished responsiveness to infant cues (Murray et al., 1996) and display more negative, hostile, or disengaged parenting behaviors (Lovejoy et al., 2000). These disruptions in maternal-infant interactions have been linked to lower cognitive functioning and adverse emotional development in children. Furthermore, when mothers experience chronic depression, their children are at an elevated risk for behavioral problems (Oberlander et al., 2007) and later psychopathology, including anxiety, disruptive, and affective disorders. On the other hand, the remission of depression in mothers is associated with a reduction or remission in psychiatric diagnoses in their children (Weissman et al., 2006).

In low-income countries, maternal depression has been associated with both malnutrition and higher rates of diarrheal illness in children (Rahman et al., 2008). The consequences of maternal depression extend to social, emotional, and cognitive developmental domains in children. Those growing up in households with depressed mothers face a heightened risk of experiencing psychiatric symptoms, both internalizing and externalizing, and are more prone to developing a wide range of psychiatric disorders, including depressive and anxiety disorders, oppositional defiant disorder, and conduct disorder (Teti & Goodman, 2008).

Management Of Postpartum Depression:

There are two main types of interventions for Postpartum Depression: psychological and medical. Medical interventions involve the use of medications such as anti-depressants, antianxiety drugs, and antipsychotic drugs if necessary. On the other hand, psychological interventions includes psycho-education, cognitive-behavioral therapy, interpersonal therapy, family therapy, and supportive therapy.

Psycho-educational interventions have been consistently effective in managing common perinatal mental disorders. These interventions focus on promoting problem-solving, coping skills, role transitions, interpersonal skills, and addressing the need for support systems. Cognitive-behavioral therapy and interpersonal therapy have shown particular success in helping individuals reframe unhelpful thinking patterns (Appleby et al., 1997).

Both individual social and psychological interventions have demonstrated equal efficacy in treating Postpartum Depression (Dennis, 2007; Pearlstein, 2009). Social interventions include individual counseling and peer support, while psychological interventions involve cognitive-behavioral therapy (CBT) and interpersonal therapy (IPT) (Fitelson et al., 2010). IPT has been particularly effective in fostering a strong bond between the mother and infant (Stuart, 2012; Smith et al., 2016). Other therapy forms, such as group therapy, home visits, counseling, and ensuring adequate sleep for the mother, may also be beneficial (Beck, 2008).

For mild to moderate cases of Postpartum Depression, psychological interventions or

antidepressants are typically used as treatment options. However, for women experiencing moderate to severe PPD, a combination of psychological and medical interventions may yield greater benefits (Langan, 2016).

In addition to traditional treatments, light aerobic exercise has shown promise in managing mild and moderate cases of Postpartum Depression (McCurdy et al., 2017; Prtchett et al.,2017). Moreover, maintaining a nutritious diet with sufficient consumption of vegetables, fruits, legumes, seafood, milk, dairy products, and olive oil has been associated with a potential 50% reduction in postpartum depression risk (Chatzi et al., 2011). Research also suggests that exercise and physical activity offer significant benefits in reducing depression symptoms comparable to medicinal effects (Dinas et al., 2011). Exercise has the added advantage of enhancing self-confidence and aiding in overcoming negative self-assessments related to depression. Furthermore, exercise can help women focus on their environment and improve problem-solving skills (Daley et al., 2007).

Conclusion:

Postpartum depression is a unique and often underestimated disorder, yet its consequences are devastating, significantly impacting maternal mortality and morbidity, making it a critical public health concern for women and their families. This form of depression occurs after childbirth, which is a life-altering experience that can be both exciting and overwhelming for new parents. The good news is that postpartum depression is a medical condition that can be effectively treated with medication and counseling.

Raising public awareness about postpartum depression and its effects on children is of utmost importance; as such awareness could encourage more mothers to seek necessary treatment. The study reveals a high prevalence of depression among postpartum women, but unfortunately, the rate of seeking healthcare for depression remains low. To tackle this issue, it is crucial for health policymakers to incorporate mental health components into reproductive and child health programs. Moreover, health professionals and workers must receive proper training to promptly raise awareness and provide effective treatment for postpartum depression among women.

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