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Postpartum Depression: Neglected Issue in Maternal Health

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ABSTRACT

Mental health challenges can develop during the prenatal and postpartum periods when women face physical, mental, and social adjustments. The major public health concern is postpartum depression, which poses a serious threat to mothering and has serious consequences for families. The number of women who experience depression during pregnancy or within the first 12 months after giving birth ranges from 10 to 20 percent. The clinics primarily use questionnaires to diagnose patients. Treatment options include psychotherapy and antidepressant medications. Postpartum depression and the factors associated with postpartum depression among women of childbearing age are the focus of this review.

Keywords: Maternal Health; Mental Health; Postpartum Depression.

INTRODUCTION

Childbearing is challenging and exhausting, and a female undergoes hormonal, physical, emotional, and psychological changes throughout pregnancy.[1] Postpartum depression (PPD) is a critical well-being issue that can affect about 15% of the female population after giving birth, and it often conveys significant adverse consequences to the offspring.[2] Another study reported that approximately 10 to 20 percent of women experience depression either during pregnancy or in the first 12 months postpartum.[3]

Postpartum depression (PPD) is one form of depression that impacts some women after giving birth. The symptoms include bad temper, anxiety, sadness, fluctuations in sleeping and eating patterns, and low energy. The rate of PPD varies widely in different regions and populations [(4)]. Postpartum depression most commonly occurs within six weeks after childbirth, and it occurs in about 6.5% to 20% of women. It occurs more usually in adolescents, mothers who deliver premature infants, and women living in urban areas. African American and Hispanic mothers reported symptoms within two weeks of delivery, unlike white mothers, who reported the onset later.[5]

Women at the possibility of suffering from postpartum depression (PPD) is rarely known, although it is a well-known clinical phenomenon [(6)]. Ordinary risk factors of PPD are poor economic status, pregnancy-associated complications, low education, unplanned pregnancy, housewife, inadequate social support from family members, and feeding by formula. The common risk factors that subsidize the development of PPD are

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young age, unplanned pregnancy, pregnancy-associated complications, low level of education, domestic responsibilities, poverty, lack of relationship with family, inadequate social support from family members, type of delivery, gender of baby, the baby feeding method, health of baby, care of baby, and lack of access to effective postpartum care [7]. Dennis and McQueen reported that women with depressive symptoms at the early stage of the postpartum period were associated with an increased risk for negative infant feeding outcomes [8]. A Saudi study showed that more than a quarter of women likely to have PPD needed intensive observing, assistance, teaching, diagnostic assessment, and possible treatment by primary healthcare physicians or specialists [9].

In addition to causing bonding problems with the baby, peripartum depression can affect sleep and feeding patterns. In the longer term, children of mothers with peripartum depression are at greater risk for cognitive, emotional, developmental, and verbal deficits and impaired social skills [10,11].

How does postpartum depression manifest?

Postpartum mood disorders can be divided into three types:

Between 50% and 75% of women experience the baby blues after giving birth. Symptoms of baby blues include frequent, prolonged crying without apparent reason, sadness, and anxiety. After delivery, the condition usually begins within a week (one to four days). Without treatment, the condition usually subsides within two weeks. Getting support and asking for help from friends, family, and partners is the best thing the mother can do.[12, 13]

Postpartum depression

About one in seven new parents experience postpartum depression, a far more serious condition than the baby blues. With each pregnancy, the risk of postpartum depression increases to 30% if the mother has already suffered from it. The mother may experience alternating highs and lows, frequent crying, irritability, fatigue, feelings of guilt, anxiety, and inability to care for the baby. Mild to severe symptoms may appear within a week of delivery or gradually over a year later. Despite the fact that symptoms can last several months, psychotherapy or antidepressants are very effective in treating depression.[12,14]

Postpartum psychosis

In the case of postpartum psychosis, emergency medical attention is required. It affects only one in 1,000 people after delivery. Symptoms usually appear shortly after delivery and last for a few weeks to several months. Anxiety, confusion, feelings of hopelessness and shame, insomnia, paranoia, delusions, rapid speech, and mania are some of the symptoms. Due to the increased risk of suicide and harm to the baby, postpartum psychosis requires immediate medical attention. A combination of hospitalization, psychotherapy, and medication is usually used in the treatment.[12]

The etiology

In any trimester of pregnancy, depression and anxiety can lead to PPD.[5]

Risk Factors

Undiagnosed depression during pregnancy is the leading cause of postpartum depression. There is evidence that many risk factors are associated with maternal depression, and women experiencing these risk factors should be observed by providers and screened regularly during pregnancy and postpartum.

Psychological: Anxiety and depression, premenstrual syndrome (PMS), negative attitudes toward the baby, and a reluctance to reveal the baby's gender are perpetual factors contributing to postpartum depression.

Obstetric risk factors include emergency cesarean sections and hospitalizations during pregnancy. In addition to meconium passage, umbilical cord prolapse, preterm birth, and low hemoglobin, PPD is associated with low birth weight.

Social factors: Postpartum depression can be caused by a lack of social support. Violence against the spouse, including sexual abuse, physical abuse, and verbal abuse, can also contribute to the development of the disease. PPD is associated with smoking during pregnancy.

Lifestyle factors such as eating habits, sleep patterns, and physical activities may affect postpartum depression. Vitamin B6 is known to play a role in postpartum depression via its conversion to tryptophan, affecting mood. Postpartum depression is associated with decreased sleep, one of the factors influencing depression risk. Exercise and physical activity tend to reduce depressive symptoms. As a result of exercise, endogenous endorphins and opioids are released, which improves mental health. This also improves self-confidence, increases problem-solving capacity, and helps them focus on their surrounding environment.[15]

Pathophysiology

Postpartum depression's pathogenesis is unknown. Genetics, hormonal and psychological factors, and social stressors have been implicated in developing PPD.[16,17]

Following delivery, women susceptible to stress can experience rapid changes in reproductive hormones such as estradiol and progesterone. Depressive symptoms can result from these changes. Prolactin and oxytocin also play an essential role in PPD pathogenesis [(18)].

SIGNS AND SYMPTOMS

- Everyone's warning signs are different, but they can include:
- Loss of interest or pleasure in former hobbies
- Overeating or undereating
- Anxiety or panic attacks all the time or most of the time
- The thoughts are racing, scary
- Sense of guilt or worthlessness - blaming oneself
- Anxiety, anger, or irritability-mood swings
- Crying uncontrollably for long periods of time due to sadness
- Having a fear of not being a good mother
- Anxiety about being left alone with the baby
- The misery
- A lack of sleep, excessive sleep, difficulty falling asleep or staying asleep.
- Family, friends, and the baby seem uninterested
- Making decisions, concentrating, or remembering details is difficult
- A desire to harm the baby or oneself.

The severity and frequency of these symptoms can vary from woman to woman due to peripartum depression. Women can feel ashamed, guilty, or isolated when they experience symptoms such as these. Within four weeks of delivery or during pregnancy, peripartum depression is diagnosed [(19,14)].

Diagnosis of PPD

There remains controversy regarding the criterion for the onset time of PPD [(20)]. In clinical practice and various studies in the literature, the onset time for PPD has been generalized to up to 1 year postpartum [(21)]. Peripartum depression is an actual illness that should be taken seriously, despite the fact that there is no specific diagnostic test for it [(19)]. The Edinburgh Postnatal Depression Scale (EPDS) is a set of 10 screening questions that can indicate whether a parent has symptoms common in women with depression and anxiety during pregnancy and the year following the birth of a child. The accuracy of the test was similar across all reference standards and subgroups, including pregnant and postpartum women [(22)].

Who Is at Risk?

Peripartum depression may be caused by rapid changes in sex hormones, stress hormones, and thyroid hormone levels during pregnancy

and after delivery. Physical changes during pregnancy, changes in relationships and at work, worries about parenting, and lack of sleep are also factors to consider. It is not uncommon for women who have recently given birth (or who are gestational carriers or surrogates) to suffer from symptoms of peripartum depression. Pregnant and labored women are more likely to experience depression or other mood disorders if they have been depressed before (or have a family history of depression), if they are experiencing particularly stressful life events in addition to pregnancy, or if they lack family and friend support.[19]

Fathers: Pregnancy/childbirth and depression

Symptoms of peripartum depression can also affect new fathers, such as fatigue and changes in eating and sleeping habits. In the first year after a child is born, approximately 4% of fathers experience depression. Depression is more likely to affect younger fathers, those with a history of depression, and fathers with financial difficulties.[23]

Can postpartum depression be prevented or avoided?

Postpartum depression cannot be prevented or avoided. It is recommended to screen for depression in the general adult population, including pregnant and postpartum women.[14]

Treatment

The struggles of many women during pregnancy and childbirth go unnoticed, dismissed as a normal part of the process. Treatment for depression during pregnancy is essential, and greater awareness and understanding can lead to better outcomes for women and their babies [(19)]. Postpartum depression is treated much like any other depression [(14)].

Psychological treatment usually happens through counseling (or psychotherapy), either one-on-one with a psychologist or in a group setting [(24)]. Therapeutic treatment for PPD contains antidepressants, along with Antidepressant medication is the most common treatment for PPD.[25]

Living with postpartum depression

Feeling depressed does not mean that a mother is the wrong person. It does not mean that the mother did something wrong or brought this on herself. It also does not mean that the mother does not love the baby. It should be remembered that many other women have had the same experience.[14]

Many studies have shown that during the screening of selected women, most healthcare facilities do not report this issue.[26,27]

The disturbances of PPD can range from two weeks of mild depression to the onset of psychosis, a life-threatening situation for the mother and baby [(28)].

CONCLUSIONS

During the postpartum period, postpartum depression affects new mothers and their children adversely. There are several risk factors for PPD, including biological, psychosocial, and environmental factors. Mothers who develop depression during pregnancy should be identified and closely monitored by their postpartum nurse or primary care provider. There is a need for education and support for these women regarding the available treatments.

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REFERENCES

1. Zauderer C. Postpartum depression: how childbirth educators can help break the silence. J Perinat Educ. 2009 Spring;18(2):23-31

2. Yu, Y., Liang, H., Chen J., Li Z., Han Y., Chen J., and Li J. Postpartum Depression: Current Status and Possible Identification Using Biomarkers. Frontiers in Psychiatry, vol 12, 2021. https://www.frontiersin.org/articles/10.3389/fpsyt.2021.620371. Doi 10.3389/fpsyt.2021.620371

3. Gaynes BN, Gavin N, Meltzer-Brody S, Lohr KN, Swinson T, Gartlehner G, Brody S, Miller WC. Perinatal Depression: Prevalence, Screening Accuracy, and Screening Outcomes. Agency for Healthcare Research and Quality. Evidence Report/ Technology Assessment, Number 119, 2005

4. Li, Q., Yang, S., Xie, M. *et al.* Impact of some social and clinical factors on the development of postpartum depression in Chinese women. *BMC Pregnancy Childbirth* **20**, 226 (2020). https://doi.org/10.1186/s12884-020-02906-y

5. Mughal S, Azhar Y, Siddiqui W. Postpartum Depression. [Updated 2022 Jul 20]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2022 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK519070/

6. Nielsen, D., Videbech, P., Hedegaard, M., Dalby, J. and Secher, N.J. (2000), Postpartum depression: identification of women at risk. BJOG: An International Journal of Obstetrics & Gynaecology, 107: 1210-1217. https://doi.org/10.1111/j.1471-0528.2000.tb11609.x

7. Alshikh Ahmad, H., Alkhatib, A. & Luo, J. Prevalence and risk factors of postpartum depression in the Middle East: a systematic review and meta–analysis. BMC Pregnancy Childbirth 21, 542 (2021). https://doi.org/10.1186/s12884-021-04016-9

8. Dennis CLC-L, McQueen K. The relationship between infant-feeding outcomes and postpartum depression: a qualitative systematic review. *Pediatrics.* (2009) 123:e736–51. doi: 10.1542/peds.2008-1629

9. Alonazi HG, Jahan S. Prevalence of Postpartum Depression among Women in Childbearing Age Attending Primary Health Care Centres, Qassim Region. Health Psychol Res. 2022 May 30;10(3):35642. doi: 10.52965/001c.35642.

10. Field, T. Postpartum depression effects on early interactions, parenting, and safety practices. Infant Behav Develop. 2010; 33:1-6.

11. Brand, SR, Brennan, PA. Impact of antenatal and postpartum maternal mental illness: How are the Children? Clin Obstet Gynecol 2009; 53:441-55

12. Cleveland Clinic. Postpartum Depression. 2022. https://my.clevelandclinic.org/health/diseases/9312-postpartum-depression

13. ACOG. Postpartum depression. 2021. (https://www.acog.org/womens-health/faqs/postpartum-depression) Accessed 22/8/2022.

14. American Academy of Family Physicians. Postpartum Depression (PPD). 2020. (https://familydoctor.org/condition/postpartum-depression/) Accessed 20/8/2022.

15. Ghaedrahmati M, Kazemi A, Kheirabadi G, Ebrahimi A, Bahrami M. Postpartum depression risk factors: A narrative review. J Educ Health Promot. 2017;6:60.

16. Couto TC, Brancaglion MY, Alvim-Soares A, Moreira L, Garcia FD, Nicolato R, Aguiar RA, Leite HV, Corrêa H. Postpartum depression: A systematic review of the genetics involved. World J Psychiatry. 2015 Mar 22;5(1):103-11.

17. O'Hara MW, McCabe JE. Postpartum depression: current status and future directions. Annu Rev Clin Psychol. 2013;9:379-407.

18. Cardaillac C, Rua C, Simon EG, El-Hage W. [Oxytocin and postpartum depression]. J Gynecol Obstet Biol Reprod (Paris). 2016 Oct;45(8):786-795.

19. Field, T. What is Peripartum Depression (formerly Postpartum)? American Psychiatric Association. 2020. https://psychiatry.org/patients-families/peripartum-depression/what-is-peripartum-depression

20. Yim IS, Schetter CD. Biopsychosocial predictors of perinatal depressive symptoms: moving toward an integrative approach. *Biol Psychol*. (2019) 147:107720. doi: 10.1016/j.biopsycho.2019.107720

21. American Psychological Association (APA). Postpartum depression: Causes, symptoms, risk factors, and treatment options. 2022. https://www.apa.org/pi/women/resources/reports/postpartum-depression

22. Levis B, Negeri Z, Sun Y, Benedetti A, Thombs B D. Accuracy of the Edinburgh Postnatal Depression Scale (EPDS) for screening to detect major depression among pregnant and postpartum women: systematic review and meta-analysis of individual participant data *BMJ* 2020; 371 :m4022 doi:10.1136/bmj.m4022

23. Davé S1, Petersen I, Sherr L, Nazareth I. Incidence of maternal and paternal depression in primary care: a cohort study using a primary care database. Arch Pediatr Adolesc Med. 2010 Nov;164(11):1038-44.

24. Green SM, Haber E, Frey BN, McCabe RE. Cognitive-behavioral group treatment for perinatal anxiety: a pilot study. Arch Womens Ment Health. (2015) 18:631–8. doi: 10.1007/s00737-015-0498-z

25. Pearlstein TB, Zlotnick C, Battle CL, Stuart S, O'Hara MW, Price AB, et al. Patient choice of treatment for postpartum depression: a pilot study. *Arch Womens Ment Health.* (2006) 9:303–8. doi: 10.1007/s00737-006-0145-9

26. Akwa A. (2015). What is the Importance of Educating Women on Postpartum Depression?. Retrieved from Sophia, the St. Catherine University repository website: https://sophia.stkate.edu/msw_papers/420

27. Bener A, Burgut FT, Ghuloum S, Sheikh J. A study of postpartum depression in a fast developing country: prevalence and related factors. Int J Psychiatry Med. 2012;43(4):325-337. doi:10.2190/pm.4 3.4.c

28. Yang L, Di YM, Shergis JL, et al. A systematic review of acupuncture and Chinese herbal medicine for postpartum depression. Complement Ther Clin Pract. 2018;33:85-92. doi:10.1016/j.ctcp.2018.08.00.