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Uncovering the Concealed Part of Motherhood-Postpartum Depression in Mothers

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Abstract

Introduction: Motherhood is the most pleasing experience of a woman's life. Birth of a child gives birth to new hopes and ambitions. But Post-partum Depression is a condition when this blessing turns into curse. It can affect the mother, the partner and the child and can even lead to infanticide as well as maternal death, often by suicide.

Method: A qualitative systematic review was conducted through electronic medium to explore the relevant literature. Various databases i.e. Pubmed, Google search engines, Science Direct, JPMA, the Cumulative Index to Nursing and Allied Health Literature CINAHL and SAGA were used. Manual search was also done by accessing articles from 2000 till 2013. Both authors independently extracted data including study design, participants (number and characteristics), and results.

Findings: According to American Psychological Association, an estimated 9-16 percent of postpartum women experience Postpartum Depression (PPD). Moreover, among women who have already experienced PPD following a previous pregnancy, the prevalence estimates increase to 41 percent. The prevalence of PPD in Asian countries ranges from 3.5 percent to 63.3 percent.

Conclusion: PPD is a prevalent illness that can lead to severe complications. Its causes can be maternal or situational and therefore its prevention is recommended to decrease its burden in public health. Nurses can play a significant role in identifying women at risk for PPD and support them get necessary treatment. Community teachings, screening programs, psychotherapies, social support are some strategies for the prevention of PPD at different levels. Child care and family responsibilities, lack of awareness, stigma, feeling of shame and guilt are the hurdles in the path of preventing PPD.

Keywords: Postpartum depression; Stressors; Psychotherapy; Support

Introduction

Motherhood is the most fulfilling experience of a woman's life. Birth of a child gives birth to new hopes and aspirations. But what if this blessing turns into curse? What if the baby's arrival brings anxiety, exhaustion and weepiness instead of joy and excitement? And what if mother starts having thoughts of killing herself or her baby instead of feeling privileged. All this becomes reality when the mother suffers from Postpartum Depression (PPD). Postpartum depression is a term applied to depressions that are prevalent during postpartum period, which in research and clinical practice is viewed as up to one year after childbirth [1-5]. According to the (DSM-V), the diagnosis of depression during the postpartum period with peripartum onset is the episode occurring during pregnancy as well as in the four weeks following delivery. According to Kim & Swaine [6], fathers also experience significant changes in life after childbirth. Fathers also adjust to an array of new and demanding roles and tasks during the early postpartum period. Nowadays, depression in fathers is known as Paternal Postnatal Depression (PPND).

Prevalence of PPD

PPD can affect the mother, the partner and child. According to American Psychological Association [3], an estimated 9-16 percent of postpartum women experience PPD. Moreover, among women who have already experienced PPD following a previous pregnancy, the prevalence estimates increase to 41 percent. The prevalence of PPD in Asian countries ranges from 3.5 percent to 63.3 percent [4]. According to Paulson and Bazemore [7], Paternal Postnatal Depression (PPND) affects up to 10 percent of fathers throughout the world. Therefore, highlighting the prevalence of PPD there is the need to have a look on this concealed part of life.

Risk Factors of PPD

Major risk factors may include history of previous depression, history of PPD, history of stressful life events, prenatal depression and anxiety, child care stress, marital dissatisfaction and lack of social and emotional support. Socio-cultural practices including seclusions and several dietary restrictions in postpartum period and various cultural taboos are some of the factors associated with PPD [8,9]. Poverty is another factor causing multiple worrying thoughts to parents regarding upbringing of newborn [10]. Childbirth and caring for a newborn in addition to pre-existing responsibilities can exacerbate stress level [11]. Furthermore lack of husband-attachment and family

support are augmenting factors for PPD since women in postpartum period need emotional attention and quality care, therefore, its lacking can result in PPD [12]. Lastly, introvert women are prone to PPD because they tend to hide their feelings and non-ventilation of feelings can provoke PPD [13]. In addition, hormonal alterations including cortisol and melatonin imbalance results in disturb sleep-wake cycle [14], progressing to stage when mothers exhibit symptoms including mood swings, anxiety, insomnia, decreased concentration and lack of joy, pleasure and interest in life [15].

Symptoms of PPD

Postpartum depression can be manifested as loss of appetite, insomnia, intense irritability and anger, overwhelming fatigue, loss of interest in sex, lack of joy in life, feelings of shame, guilt or inadequacy, severe mood swings, difficulty bonding with your baby, withdrawal from family and friends, thoughts of harming oneself or the baby [16].

Treatment of PPD

To overcome the symptoms following could be the pharmacological measures. Antidepressants including serotonin-selective reuptake inhibitors (SSRI) can be used to decrease major depressive symptoms and relapse of PPD. These are usually the first-choice medicine for treating postpartum depression. SSRIs can also be used to relieve severe anxiety and depression during pregnancy and to prevent PPD in high-risk women [17]. However, the use of antidepressants in breastfeeding women, is debatable as it passes into breast milk, thus delivered to the infant. Yet, the quantity of drug in infants' sera is found to be small with no evidence of infant's harm due to mother's medication usage [5].

According to Figueiredo et al. [18], exclusive breastfeeding may help to reduce symptoms of depression from childbirth to 3 months postpartum. In addition, women with negative early breastfeeding experiences are more likely to have depressive symptoms at two months postpartum [19]. Conversely, in other studies, breastfeeding triggers depressive symptoms due to disturbances in sleep-wake cycle, problems in milk production and physical health of child (decrease sucking). However, counseling sessions on breastfeeding before postpartum can decrease stressors [14].

Prevention of PPD at Different Levels

To overcome amplification of symptoms, following preventive measures are recommended. For primary prevention, it is speculated that improvements in major risk factors can decrease PPD. Community teachings to the clients of reproductive age can prevent its incidence. Moreover, clinical assessment and risk evaluation during preconception are useful strategies for early identification of PPD as they help to identify history of depressive episodes, family history, life stressors, role changes and patient's concern and attitude towards pregnancy [14]. At secondary level, screening tools can be used. Two most frequent screening tools are Edinburgh Postnatal depression Scale (EPDS) and Patient Health Questionnaire-9 (PHQ-9) [20,21]. These tools help in early identification of disease by assessing clients for seven dimensions including sleeping, eating, anxiety, cognitive-impairment, self-perception and suicidal-ideation [22]. Hence, tertiary prevention requires a number of interventions including antidepressants, cognitive-behavioral therapy, interpersonal psychotherapy, social support, stress reduction, dietary management, exercise, sleep-hygiene, breastfeeding and family planning. In

addition, National Institute for Clinical Excellence and English Department of Health has recommended psychological therapies where Cognitive behavioral therapy has been as effective as antidepressants in treating PPD [23]. Counseling, psychotherapies, mindfulness exercises and relaxation-techniques help to decrease emotional instability and to strengthen positivity towards role transitions [14]. Sessions can be conducted for couples to explain partners about role transition and feelings of motherhood aiding in developing social support for mothers by their partners [14]. Furthermore, these sessions for couples can guide them to relate the efficacy of family planning method and reduce depressive symptoms [14]. Furthermore, nutrition can be used as primary, secondary and tertiary prevention. Nutrients like vitamin D, vitamin B3, can be avoided in mothers with increased risk of depressive symptoms. Conversely, methylfolate is effective after development of depression to reduce the symptoms [14]. Yet, depending on individual's resilience, the interventions are decided from aforementioned [14]. Hence mother can recover by abiding tertiary preventions. However, if neglected, the consequences may result in chronic depression or suicide.

Barriers in Prevention of PPD

Despite of these measures, there exist many barriers for each level of prevention. Firstly, women assume that their symptoms are usual part of motherhood rather than depression [24]. Thus, nurses providing care to perinatal women should educate on manifestations of PPD before its risk period, highlighting the misconceptions and myths not only to patient but also the family and ensure social support for role adjustment. Therefore, keeping demographic profiles of women in mind is imperative. For that, several forms of public education can be used like face to-face communication, television and internet. Printed information and websites on PPD must be verified for content accuracy and literacy levels [24]. A survey on PPD revealed that 57 percent women with moderate to severe symptoms did not seek assistance from health provider [25-27]. General barriers include childcare and family responsibilities, lack of awareness about treatment options, stigma, feeling of shame and perceived ineffective treatment. Thus, community health nurses (CHN) should conduct home visit for pregnant and postpartum women and provide education, social support, referral to healthcare and mental-health delivery system after screening. For that, training of CHNs is the first step as it is found to be difficult for them to distinguish between PPD and usual depressive symptoms. However, reluctance to allow CHNs in homes was also observed because of past experiences and cultural taboos. If they are allowed to enter, some clients are found to be reluctant to discuss mental health concerns because they feel that these issues should be concealed. At times, family members' interruptions towards questions asked by CHNs hinder the screening process. If these concerns are discussed, the EPDS screening tool has been found to over-identify and under-identify cases. However, several barriers to referring postpartum depressive mothers to mental-health services have include practical barriers (logistical impediments like lack of transportation, difficulty paying for mental healthcare, health-insurance limitations and sometimes childcare barrier like inability to afford daycare as children are not allowed to be taken at sessions), personal barriers (lack of motivation, mistrust and comparatively low priority of mental-health than other life stressors), stigma towards psychiatric disorder, mental-health system barriers (lack of services, inhospitable behavior of staff) and internal agency barriers (limited resources and services, overburdened staff).

Strategies to Overcome the Barriers

Many of these barriers can be addressed for example initial mental-health appointment can be arranged with transportation. Additionally, collaborative approach with mental-health agencies can help clients get appropriate services. Also, other's inspirational stories who responded positively to treatment regime can be shared to motivate patients. However, gaining trust and building relationships is a key which can be done by providing support and reducing client's isolation. However, there is a need for effective trials in which these recommendations are evaluated in community settings that are designed to overcome common barriers. It is an important step in future research [5].

According to O'Hara [5], most researchers have used samples in one location. Some studies have a broader reach but none have been designed to find incidence, prevalence and onset relative to childbirth. Although good quality work has been done in determining consequences of maternal depression on child, but studies on its long-term consequences for the child are relatively limited. Additionally, it is likely that PPD reflect a specific childbirth-related diathesis that may represent a specific sensitivity to disruption in ovarian hormones occurring in menstruation, pregnancy and pre menopause. If this diathesis exists, determining its nature is a significant goal for research as it can develop specific intervention to prevent and treat PPD. Further, Sealy et al. [24] recommended demographic variables and cultural differences to be considered in future researches. Lastly, a policy needs to be established to direct PPD information's content and timing for perinatal women, their social support networks, health professionals and general public.

Conclusion

In conclusion, PPD represents substantial public health concern with extensive consequences for parents and children. It is a prevalent illness that can lead to severe complications. Its causes can be maternal or situational and therefore its prevention is recommended to decrease its burden in public health. If primary prevention fails, screening for early detection should be considered and if the diseases progresses, antidepressant compliance and effective psychotherapies are useful along with recommended diet, proper sleep and exercise. However, more research is required to uncover its several important aspects. After all, mother-child relationship is the most beautiful relation in the world that should not be ruined because of postpartum depression.

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