

Review Article

Postpartum Mood Disorders: Sometimes More than "Baby Blues."

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Abstract:

Postpartum mood disorders are a significant clinical and public health concern. While pregnancy is an immense source of happiness and pleasure for a woman, it is also a stressful time. During pregnancy, there is a significant increase in the level of steroidal hormones. Women become vulnerable to numerous mood disorders when these childbirth hormones are suddenly withdrawn. These mood disorders range in severity from mild postpartum blues to more serious mood disorders such as postpartum depression and psychosis. Approximately 50% to 80% of new mothers experience postpartum blues within the first few days of their child's birth.

Postpartum depression, while less prevalent (occurring in 10-15% of deliveries), has a profound impact on the health of both the mother and the baby. Unfortunately, these forms of mental illnesses in women are usually undiagnosed, untreated, and underestimated. Postpartum psychosis is exceedingly rare, involving about 1-2 mothers out of every 1000 live births, but it is a true psychiatric emergency. This article reviews postpartum mood disorders, their risk factors, signs and symptoms, complications, screening, treatment, and nursing care for these mothers.

Key words: Postpartum mood disorders, Postpartum depression, Baby blues.

Introduction:

Depression is a particularly serious illness for women. Females are twice as likely to suffer from mood disorders than males. Around 20% of women, particularly those of reproductive age, may experience some form of depression during their lifetime, making it one of the most serious public health concerns^{1,2}. Giving birth is a physically and emotionally exhausting process. Throughout pregnancy, a female undergoes numerous hormonal, physical, emotional, and psychological changes. Significant changes take place in the mother's personal and familial spheres. A woman may experience a range of emotions following childbirth, from joy and pleasure to sadness and crying bouts^{3,4}. Throughout pregnancy, a woman experiences a variety of stressors, including nausea, vomiting, stretch marks, bodily deformity, breast tenderness, pregnancy complications, delivery anxiety, fear of parenthood, physical discomfort, and more.

On the other hand, increasing demand for newborn care, changes in family and marital relationships, and the impact on job and social activities all lead to significant stress following delivery^{5,6}. Since Hippocrates' time, a link between the postpartum period and psychiatric illnesses has been established⁷. The American Psychiatric Association included the diagnostic classification of 'Psychosis associated with childbirth' for the first time in 1968⁸. According to the ICD-10 classification of mental and behavioral disorders published by the World Health Organization in 1992, postpartum disorders begin within six weeks of delivery and do not meet the criteria for mental and behavioral disorders classified elsewhere⁹. The consequence of postpartum psychiatric illness can be substantial. Unfortunately, these issues are frequently overlooked, unrecognized, and untreated¹⁰. Postpartum depression poses a serious risk to the mother, her family, and the infant she has just delivered. It is imperative that health care providers recognize and treat this specific subset of women¹¹.

Types of postpartum mood disorders:

Women may experience a variety of psychological problems following childbirth, including the following:

1. Postpartum blues
2. Postpartum depression
3. Postpartum psychosis

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1. *Postpartum blues:*

Postpartum blues, also called as 'baby blues' are a transient state of increased emotional reactivity that affects around 50% to 80% of women who have recently given birth^{12,13}. Symptoms often begin three to four days after delivery and subside by the tenth day¹⁴. Mood lability, tearfulness, irritability, changed sleep and appetite patterns, and anxiety are the most common characteristic symptoms of the blues. Other documented symptoms include headaches, confusion, a lack of concentration, and absent-mindedness. Although the term 'blues' implies the presence of a low mood, depression is a necessary component of its clinical pattern. The fundamental distinction is that if the depression lasts more than two weeks, it is defined clinically as postpartum depression.

The etiology of postpartum blues has still not been firmly demonstrated¹¹. There are two leading hypotheses:

1. The first is a change in mood as a result of sudden hormone withdrawal. There is little evidence that the absolute levels of estrogens and progesterone is related to postpartum blues¹⁵. However, the chance of postpartum blues increases when the change in the level of these hormones is higher between pregnancy and the postpartum period. In addition, it has been found that progesterone metabolite allopregnanolone, an anxiolytic γ -aminobutyric acid agonist is significantly lower in women experiencing postpartum blues¹⁶.

2. An alternate hypothesis is that postpartum blues are caused by activation of a hormonal mechanism associated with mammalian mother-infant bonding behavior, which is primarily regulated by the hormone oxytocin¹².

Most cases resolve within 10 days, and 75% of them are uneventful. However, between 20% and 25% may develop depression¹⁷.

Due to the mild and temporary nature of postpartum blues, professional intervention is often not required. All pregnant women should be informed and educated on the physiology of labor and the stress related to labor and puerperium prior to birth. Simultaneously, she should be assured that the blues are common and will subside quickly without medication. If symptoms linger for more than two weeks, women should be encouraged to seek additional evaluation¹¹.

2. *Postpartum depression (PPD):*

Postpartum depression is most prevalent within the first six weeks after childbirth. PPD affects approximately

6.5% to 20% of women. It is particularly prevalent in adolescent females, mothers who have delivered premature infants, and women who reside in urban areas³. PPD is considered when a patient experiences a major depressive episode along with the onset of peripartum, and it is not addressed as a distinct condition. It is defined as a major depressive episode with the onset of pregnancy or within four weeks of delivery. Changes in daily routine are caused by the presence of these nine symptoms on a daily basis. The diagnosis should include either depression or anhedonia (loss of interest). Symptoms include³

- * Depressed mood (subjective or observed) is present most of the day
- * Loss of interest
- * Insomnia or hypersomnia
- * Psychomotor retardation or agitation
- * Worthlessness or guilt
- * Loss of energy or fatigue
- * Suicidal ideation or attempt and recurrent thoughts of death
- * Impaired concentration or indecisiveness
- * Change in weight or appetite

Postpartum depression has an unknown etiology. There may be some association with an abrupt change of hormones like estrogen, progesterone, cortisol, and thyroid. There may be a relationship with PPD with numerous psychological factors such as marital disharmony, economic instability, women's personal psychiatric history, and family history. Occasionally, a link with obstetric complications during pregnancy and labor may be identified. PPD is unlikely to be affected by the mode of delivery. PPD may be influenced by a poor marital relationship during pregnancy and delivery, a lack of family support, conflict between the women's father's family and her in-laws' family, a lack of confidence, and unemployment. PPD may result in poor maternal-infant attachment, failure to breastfeed, terrible parenting practices, marital discord, and children's adverse physical and psychological development outcomes. A prior episode of PPD significantly increases the likelihood of developing severe depression, bipolar disorder, or future PPD. PPD is frequently underestimated and disregarded. It is critical to exercise extreme caution with new mothers, particularly those who have risk factors for depression and exhibit any symptoms of depression. Additionally, it is critical to obtain a history of drug, alcohol, and smoking use throughout the evaluation.

Several screening tools are available, the most often employed of which is the 'Edinburgh Postnatal Depression Scale (EPDS)¹⁸. The EPDS is a ten-item questionnaire that patients fill. To evaluate if patients are at risk of developing PPD, an EPDS cutoff score of 13 or above is required³. Psychotherapy and

antidepressant medicines are the first-line treatments for PPD. Psychotherapy is recommended as initial treatment for women with mild to severe PPD. Antidepressants from Selective Serotonin Reuptake Inhibitors (SSRI) are the first line of treatment for moderate to severe PPD since they are also anxiolytic, non-sedative, and well-tolerated. Additionally, Sertraline (50-100mg) and Escitalopram (5-20mg) can be administered. Antidepressants should be continued for a minimum of six months following remission. Later, they should be gradually decreased and discontinued over a six-week period. Benzodiazepines can be used to alleviate anxiety symptoms. Transcranial Magnetic stimulation (TMS) is a non-invasive therapy that uses magnetic waves to stimulate and activate nerve cells. Electroconvulsive therapy (ECT) may be used to treat patients with severe PPD who have a high suicidal inclination.

3. Postpartum psychosis:

Postpartum psychosis is a psychiatric emergency that occurs in 0.1 to 0.2% of women and often appears between 2-3 weeks after delivery. Clinical characteristics include hallucinations, sleeplessness, agitation, strange behaviors, delusions, inability to care for oneself, fear of the baby, thoughts of suicide, and infanticide.

Postpartum psychosis is more prone in women with a prior history of psychosis, bipolar disease, a family history of serious mental illness, an unmarried mother, fetal complications or death. It is also frequently seen in eclamptic patients.

As it is in the postpartum period, we should keep in mind some other differential diagnosis, like

- * Sepsis
- * Electrolyte imbalance
- * Autoimmune disorders
- * Encephalitis
- * Hypercalcemia

Postpartum psychosis is a serious illness that frequently requires hospitalization and should be treated as a medical emergency¹¹. Antipsychotics are drugs of choice. Commonly used medications include Olanzapine (2.5-20mg), Risperidone (2-6mg), and Haloperidol (5-20mg). There may be extrapyramidal syndrome. Antipsychotic medication should be continued for at least three months following symptom resolution. They should then be gradually tapered and discontinued over a six-week period. Electroconvulsive therapy is both safe and life-saving in the presence of suicidal or infanticidal tendencies. Child care assistance is mandatory. Studies report that postpartum psychosis has a good outcome if it is not associated with schizophrenia and can be managed early.

Conclusion:

Depression is common among women, particularly those of reproductive age. Childbearing and childbirth are stressful events for women; this psychological transition into motherhood is accompanied by

significant neurohormonal changes that may result in a new mother developing a variety of mental illnesses. These mental illnesses are frequently more severe than 'baby blues,' which is the most prevalent and mild form of psychiatric illness. But sometimes it may proceed to PPD and psychosis. To prevent these kinds of psychiatric illnesses, we must educate new mothers on pregnancy and labor physiology. Simultaneously, risky psychological factors should be thoroughly addressed and removed. Additionally, it is critical to recognize any mental illness promptly and to treat it appropriately and vigorously.

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