Postpartum Depression Presentation

Introduction (MOVE TO SLIDE 2)

This question is directed to our mothers on this platform; what if you woke up one day and felt like you do not want your child anymore? Felt like God made a mistake and allowed you to become pregnant? Because if you were being honest, you have felt nothing but anxiety, depression, and unhappiness since giving birth. Or, even more, you felt nothing towards the baby? What if that was you? How would you feel about that? Would you feel like a terrible mother and refuse to tell anyone what you're going through? Or would you think that this isn't normal and seek help?

Studies show that 1 in every 7 mothers experience postpartum depression (PPD), but many suffer in silence due to the stigma that comes with this illness. The one that says 'if I have these thoughts and emotions, then I am possibly a bad parent'. Well, if you or someone you know is suffering from PPD, you are not alone. And here is proof that you are not (Thorsteinsson EB, Loi NM, Farr K., 2018).

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This afternoon we will be reviewing the topic 'Postpartum Depression (PPD)'. We will be discussing what PPD is, its differential diagnoses, the risk factors and stigma associated with it, as well as the cause, pathophysiology, and complications of PPD. And we will end with the management of PPD, and a few recommendations to our healthcare providers that may help to enhance positive outcomes for those suffering from PPD.

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What is PPD?

PPD is a mental illness characterized by depression that occurs after childbirth which affects women, and less commonly, men. It occurs at least 4 weeks following childbirth, and presents with an overall feeling of sadness, extreme fatigue, inability to stop crying, increased anxiety, a sense of insecurity, suicidal thoughts, changes in appetite, and panic attacks. With these symptoms, it is very common to have it mistaken for another mental illness, so we will differentiate PPD from other common postpartum mental illness (Thorsteinsson EB, Loi NM, Farr K., 2018).

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Differential Diagnosis

The postpartum period is distinguished by overwhelming biological, physical, social, and emotional changes. It will require a mountain of adaptation, especially for a primigravida. Women are more vulnerable to psychiatric disorders in this period. They can experience a wide range of overwhelming emotions. Let's first take a look at..

Postpartum Blues (PBs) - known as ‘baby blues’ or ‘maternity blues. This is very common among women and is mostly seen in families that lack strong familial support and bonding. Symptoms include frequent crying episodes, irritability, confusion, and anxiety that usually starts within the first 10 days postpartum, and lasts up to 2 weeks.

Postpartum Psychosis (PP) - this is observed within the first 2 weeks following delivery, or within 3 months postpartum. It is regarded as a psychiatric and obstetrical emergency, and is characterised by lability of mood, elation, rambling speech, disorganised behaviour, and hallucinations or delusions. The development of PP is complex and diverse, including alternating episodes of delusions and guilt, persecution, auditory hallucinations, delirium-like symptoms and confusion; and excessive activity. These delusions usually revolve around the infant.

Postpartum Posttraumatic Stress Disorder (PP-PTSD) - this is generally characterised by tension, nightmares, flashbacks, and autonomic hyperarousal, that can continue for some weeks or months following birth.

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Postpartum Depression - For PPD, it can be difficult to distinguish from depression occurring at any other time in a woman’s life. But, in PPD the negative thoughts are mainly related to the newborn. Onset can range from a few days to a few weeks following delivery, generally in the first 4 weeks (Rai S, Pathak A, Sharma I., 2015).

This illness manifests itself as sleep disorders, mood swings, changes in appetite, fear of injury, serious concerns about the baby, much sadness and crying, sense of doubt, difficulty concentrating, lack of interest in daily activities, and thoughts of suicide.

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According to a study done, feelings of hopelessness accounts for at least 20% of maternal deaths in the course of giving birth. Coupled with that, 36% of women reported issues of fear of harming the baby, 34% reported weak attachment to the baby, and in extreme events, baby suicide attempts (Ghaedrahmati M, Kazemi A, Kheirabadi G, Ebrahimi A, Bahrami M., 2017).

This leaves us to ponder, are most reported cases of child abandonment, and babies found dead in sewers due attribution to PPD?
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DSM-5 Diagnostic Criteria

Let us dive further into this presentation by taking a look at the diagnostic criteria for PPD, as stipulated by the Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5).

According to DSM-5 diagnostic criteria, postpartum onset can be applied to the current major depressive episode of Major Depressive Disorder (MDD), and Bipolar I or II disorder. Therefore, the diagnosis of PPD requires at least 5 of 9 symptoms listed, with one that must be either depressed mood or diminished pleasure or interest in activities. These symptoms must be present most of the day for two weeks and there must be an associated decline in social and/or occupational functioning. However, a depressed mood caused by substances (such as drugs, alcohol, and medications), or that which is a part of a general medical condition, is not considered towards this diagnosis. It is also important to rule out uncomplicated bereavement (Sharma V, Sharma P., 2012) .

Diagnostic symptoms of PPD includes:

- Depressed mood
- Lack of pleasure of interest
- Sleep disturbance (insomnia or hypersomnia)
- Weight loss
- Frequent thoughts of deal or suicide
- Loss of energy
- Agitation or retardation
- Feelings of worthlessness or inappropriate guilt
- Diminished concentration or indecision

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Pathophysiology and Aetiology

The pathophysiology of PPD is generally unknown, however, it has been suggested that genetics, hormonal, psychological, and social stressors play a role in its development. Enough data accumulated positts that changes in the reproductive hormones stimulate the dysregulation of these hormones in susceptible women. Thus, this proposes a neuroendocrine development of PPD. The Hypothalamic - Pituitary - Adrenal (HPA) axis, which is responsible for the release of cortisol in trauma and stress, is known to be involved in the disease process of PPD. The HPA is usually increased during pregnancy and remains elevated up to 2 weeks after, therefore, a dysregulation of the HPA axis will lead to decreased release of catecholamines, leading to poor stress response.

It is also often observed that low levels of oxytocin, which leads to failure to lactate, is associated with the onset of PPD. During the 3rd trimester, lower levels of oxytocin are linked to increased depressive symptoms during pregnancy and following delivery (Mughal S, Azhar Y, Siddiqui W, 2022).

The cause of PPD is also associated with potential risk factors, namely psychological, obstetrical, biological, social, and lifestyle factors.

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Psychological Factors - previous history of depression and anxiety are powerful factors used to predict PPD, proving that they are more susceptible to hormonal changes. It is also reported that moderate - severe Premenstrual Syndrome (PMS), is also a factor. Other predisposing factors includes history of sexual abuse, low self-esteem, and negative attitudes towards the pregnancy.

Obstetrical Factors - a study conducted found that having 2 or more children may leave you susceptible to PPD due to higher psychological burden. However, another study conducted showed conflicting results, as that indicated that women who are nulliparous have a high prevalence. The descripances signifies that the number of children alone is not an independent factor for developing PPD.
Risky pregnancies are also an associated risk factor for PPD. There is also an association between breastfeeding, where women who breastfeed for upto 3 to 4 months following childbirth, shows lower values on the Edinburgh Postnatal Depression Scale (EPDS), and reduced risk for PPD.

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Lifestyle Factors - among the factors related to lifestyle, food intake patterns, sleep pattern, exercise, and physical activities all may affect a parent's susceptibility to PPD. It is also noted that sufficient consumption of vegetables, fruits, legumes, seafood, milk, dairy products, olive oil, and a variety of nutritious food may reduce PPD susceptibility by 50% (Ghaedrahmati M, Kazemi A, Kheirabadi G, Ebrahimi A, Bahrami M., 2017).

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<u>PPD in Men</u>

Now, though PPD is commonly heard of in women, it also affects men, and is less understood. Though the diagnostic criteria for PPD listed both women and men, there may be subtle differences in onset and presentation in men. Let's also remind ourselves of what PPD is. DSM-5 defines it as depression ‘with postpartum onset’, and as a major depressive episode during pregnancy or within 4 weeks after parturition.

Studies show it occurs in approximately 8-10% of fathers, with the highest prevalence within 3 to 6 months postpartum. Additionally, irritability, indecisiveness, and restricted range of emotion might be observed more frequently in men.

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The major risk factors for PPD in men are associated with history of depression, poverty, unintended pregnancy, marital discord, as well as sleep deprivation (Scarff JR., 2019).

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Prognosis and Complications

As we have seen, PPD affects the mother, father, and the infant as well. With that, it is vital to know that PPD has consequences far beyond just physical harm to the child. Data proves that it affects mother-infant bonding. The child is often mistreated with a very negative attitude, which can lead to complications of growth and development of the child. Children with mothers who suffer from PPD may exhibit inappropriate change in behaviour, altered cognitive development, and an early onset of depressive illness. More importantly, these children are often obese and have dysfunction in social interactions.

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Let's continue with the complications:
Our *Mothers* may develop chronic depressive disorder if PPD is not treated on time, and even if treated, they may be at risk for future development of depressive episodes.

Fathers who do not have PPD may be susceptible to depression during this stressful period, and those who have PPD may develop chronic depressive disorder and may be prone to future depressive episodes.
Infants whose parents have PPD may develop behavioural and emotional problems, which is more commonly seen as delays in language development. They may also suffer from sleep problems, eating difficulties, excessive crying, and attention deficit/hyperactivity disorder (ADHD) (Mughal S, Azhar Y, Siddiqui W, 2022).

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Stigma

With all these unfavourable signs and symptoms of PPD, and how negatively it affects everyone in the family, we are left to contemplate, what is the cause for such a low report rate for this illness? What is holding them back?

The answer is simply this, stigma. Persons with depressive illnesses do not only have to manage their symptoms (or try to), but also have to cope with the stigma and discirmination that these illnesses receive. Stigma has a large impact on help-seeking behaviours. Many choose to suffer in silence, rather than to puruse treatment, because they'd rather avoid the label of 'mental illness' and the discrimination associated with the label. Because let's face it, who would want to report that they are experiencing signs and symptoms of PPD, only to be labelled a 'bad and incompetent parent'? No one, that's who.

Stigma, in general, is linked with the illnesses or conditions that are believed to be under the individual's control, or manifested as a consequence of unacceptable social behaviour. Both of which we have just proven are not entirely correct. Personal and perceived stigma (which are those formulated from our own belief of people, as well as expectations of others beliefs), are believed to be the strongest to influence an individual's health-seeking behaviours.

In an article published by Lets Talk Stigma, Urban stated "New moms are told that this is the best time of their life and to enjoy every minute, but few ask how they are doing."

Are you guilty of this?

She mentioned it is hard for a parent to admit to themselves that things aren't going well, let alone to admit to someone else. Social media has also negatively impacted many mothers, where they compared themselves, leaving them to feel incompetent. Mothers need to be reassured that they are not alone, that postpartum mental illnesses are common and treatable. In the same article, Abraham mentioned "We put a lot of pressure on new parents. Having a baby is supposed to be a blessing, so the mother might invalidate her emotions by saying things like 'I shouldn't be sad during this happy time' (Let's Talk Stigma, 2022).

Let's take a moment to watch this short clip. https://youtu.be/-9zIAIyxOHA

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Believe them when they share their feelings, assure them they are still good mothers, women don't hear nearly enough that they are good mothers' - Abraham

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<u>Identification and Screening of women at risk</u>

PPD is often diagnosed through a clinical interview using the DSM-5 criteria. Screening tools can be used to support the diagnosis as well. The Edinburgh Postnatal Depression Scale (EPDS) evaluates postnatal depression in men and women. Due to men being less expressive than women, there is a lower cut off score for men. If the father cannot be directly assessed, the mother may complete the EPDS-Partner (EPDS-P). However, the Patient Health

Questionnaire (PHQ-9) is a more reliable screening tool for paternal PPD (Sharma V, Sharma P., 2012).

Screening for PPD can be done 2 to 6 months before childbirth. An EPDS score of greater than 10/13 (depending on the text you use) is required to determine if a patient is at risk for PPD. The PHQ-9 has different diagnostic criteria, but in general, if there are at least 4 sticks in the shaded section of each question, consider a depressive disorder.

During evaluation, it is important to include drug and alcohol history, smoking habit, all prescriptions and over the counter medications. A history of irritability, past depressive episodes, and mental health status before and after previous pregnancies are also noted.

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Management

Let's talk about the management of PPD. The treatment of PPD is wholistic and requires reassurance, familial and social support, psychoeducation, and in some cases, psychotherapy and pharmacologic treatment.

The first line treatment for moderate to severe PPD is psychotherapy and antidepressants. For parents with mild to moderate PPD, the first line treatment is psychosocial management and psychotherapy.

Pharmacotherapy -

Antipsychotics such as chlorpromazine, haloperidol, and risperidone are often first line choices for psychosis and mania, mainly because of their tolerability. They are said to be acceptable while breastfeeding, but with medical supervision. In this instance, infants must be observed carefully for hydration status, excessive sedation, feeding difficulties, and failure to gain weight. These are signs of toxicity.

Antidepressants are given for major or minor depression. Medications such as sertraline, paroxetine, and nortriptyline may be given to nursing mothers, but concern for infant safety is considered.

Lithium used for its effects as a mood stabiliser, is a very important medication for the management of PPD. And as per usual, lithium levels, thyroid and renal function should be monitored. Adequate hydration status is also mandatory. Breastfeeding while taking lithium is strongly discouraged due to concerns of secretions of drug through breast milk.

Anticonvulsants that are used for mood stabilisers such as valporic acid or carbamazepine, are both effective in PPD, and may be taken while breastfeeding.

Benzodiazepines are used to lower brain activity, manage anxiety as well as insomnia, may be used to treat acute PPD. Medications such as intramuscular (IM) lorazepam and haloperidol are used, and oral routes used only when the patient has become stabilised.

Medications prescribed to breastfeeding mothers may be given in the lowest effective dose possible, while taking into consideration dividing the daily dose to reduce peak concentrations. Peak concentrations in breast milk are attained 6-8 hours after ingestion of medication, thus, breastfeeding can be restricted to times when the milk drug concentration is lowest. Additionally, factors to consider include rate of maternal drug metabolism and metabolism of the ingested drug by infants (Rai S, Pathak A, Sharma I., 2015).

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Transcranial Magnetic Stimulation (TMS)

This procedure is non-invasive and uses magnetic waves to stimulate and activate nerve cells. These cells are underactive in people with major depression and usually done 5 times a week for 4 to 6 weeks for effectiveness. This treatment is preferred for those who are unresponsive to antidepressants and psychotherapy. The procedure is generally safe, but yields side effects of headaches, lightheadedness, scalp discomfort, and facial muscle twitching. And in severe cases, hearing loss, and mania in bipolar individuals.

Psychotherapeutic and Psychosocial Interventions

Most breastfeeding mothers with PPD prefer non-pharmacological interventions. Those such as Cognitive Behavioural Therapy (CBT), Interpersonal therapy (IPT), and Psychodynamic Therapy. These have proved to be effective in alleviating symptoms of depression (Scarff JR. 2019). This coupled with psychosocial interventions such as non-directive counselling (Sharma V, Sharma P. 2012), support groups, social support, acknowledgement of feelings and role conflicts. Additionally, employers can offer support by offering paid paternal leave to assist men in adapting to changes and manage stressors (Scarff JR. 2019).

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Nursing Management

Due to the high morbidity rate of PPD, emphasis is now placed on prevention. The nurse is in a primary position to identify women at risk for postpartum mood disorders before delivery. During the admission, the nurse may identify those at highest risk, educate and advocate for them to get available treatments. There are men and women who may benefit from early consultation with a therapist or psychiatrist (Scarff JR. 2019).

Additionally, nursing care for individuals with PPD mainly surrounds providing support and education for both parents, as well as the family. Some nursing interventions that may be implemented include (Scarff JR. 2019):

- Educating the patient on PPD
- Encouraging a healthy diet
- Providing support and encourage self-care

- Advocating for a social worker who may suggest support groups
- Encouraging the patient to engage in social activities
- Advocating for a therapist or counsellor
- Encouraging frequent breaks from baby care

In addition to this, whatever intervention that may be implemented is subsequent to the nursing diagnosis applied to the patient. Some common nanda labels that may be identified includes (Scarff JR. 2019):

- Impaired social interaction
- Disrupted family processes
- Deficient knowledge
- Chronic low self-esteem
- Hopelessness
- Grieving
- Impaired parenting

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Conclusion

To conclude, PPD is a depressive disorder with peripartum onset. One that is characterised by an overall feeling of sadness, extreme fatigue, inability to stop crying, suicidal thoughts, sense of insecurity, and negative thoughts towards infant/child.

It affects both women and men, and many suffer in silence due to fear of being stigmatised as a ‘bad parent’. As such, healthcare individuals should aim to increase feelings of being understood and accepted in patients.

PPD has no definite cause, but it is said to have a neuroendocrine development, with affecting risk factors including biological, social, obstetrical, psychological, and lifestyle factors.

Due to the nature of PPD, this illness can lead to a disrupted family dynamic which negatively impacts the joined parties.

Because of the increased morbidity of PPD, healthcare providers are prompted to increase prevention through early and regular screening of parents for PPD, whether at clinics, hospitals, or at a private practice location.

The general management is based on the severity of the illness, where the first line treatment for moderate to severe PPD is psychotherapy and antidepressants. And for mild to moderate PPD, the first line treatment is psychosocial management and psychotherapy.

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Recommendation

As we close this presentation, I would like to end with suggesting a few recommendations to our healthcare providers.

Healthcare professionals should aim to further increase awareness of PPD which may in turn decrease the negative stigma associated with this illness. We may accomplish this by:

- Reinforcing screening modalities in prenatal parents. This will identify risk factors among parents.
- Parents and families should be educated about PPD prenatally, and should be reinforced during the postpartum period. Through teaching, educators can decrease the chance of mothers and fathers suffering in silence, and without proper care. Furthermore, while doing so, we actively challenge the myths and stigma associated with PPD. And this is done through providing factual information.
- Encourage good sleep patterns, maintaining good social support, from both family and healthcare team.

References

Ghaedrahmati M, Kazemi A, Kheirabadi G, Ebrahimi A, Bahrami M. (2017) Postpartum depression risk factors: A narrative review. J Educ Health Promotion ;6:60. doi: 10.4103/jehp.jehp_9_16. PMID: 28852652; PMCID: PMC5561681.

Rai S, Pathak A, Sharma I. (2015) Postpartum psychiatric disorders: Early diagnosis and management. Indian J Psychiatry.;57(Suppl 2):S216-21. doi: 10.4103/0019-5545.161481. PMID: 26330638; PMCID: PMC4539865.

Scarff JR. (2019) Postpartum Depression in Men. Innov Clin Neurosci.;16(5-6):11-14. PMID: 31440396; PMCID: PMC6659987.

Sharma V, Sharma P. (2012) Postpartum Depression: Diagnostic and Treatment Issues.; https://www.jogc.com/article/S1701-2163(16)35240-9/pdf

Stigma and Postpartum Depression (2022). Let's talk Stigma. https://letstalkstigma.org/stigma-and-postpartum-depression/

Thorsteinsson EB, Loi NM, Farr K. (2018) Changes in stigma and help-seeking in relation to postpartum depression: non-clinical parenting intervention sample. PeerJ.;6:e5893. doi: 10.7717/peerj.5893. PMID: 30425892; PMCID: PMC6230434.

Mughal S, Azhar Y, Siddiqui W, (2022) Postpartum Depression (Nursing). In: StatPearls. Treasure Island (FL): StatPearls Publishing; 2022 Jan-. https://www.ncbi.nlm.nih.gov/books/NBK568673/

Postpartum Depression Nursing Diagnosis. (2022). NurseStudy.net. https://nursestudy.net/postpartum-depression-nursing-diagnosis/