Free research paper about postpartum depression

Family, Parents

Pathophysiology

Pathophysiology of postpartum depression can be explained based on several risk factors associated with the mood disorder. One the major risk factor that may result in postpartum depression is the history of premenstrual anxiety disorder. Additionally, presence of a history of depression contributes to postpartum depression. The postpartum depression may also develop in women who have experienced a medically complicated pregnancy or delivery (McGarry, 2012). Furthermore, unplanned pregnancies and adolescent mothers are more likely to have postpartum depression. According to Zuehlke (2008), lack of social support contributes to cases of postpartum depression. This may be because of marital problems or lack of a firm social support source.

Etiology of Postpartum depression

Different biological factors contribute to the development of postpartum depression. After birth, there are drastic hormonal changes in the body of a woman, which results in the changing the function of the endocrine gland. The hormonal imbalance is attributed causes the postpartum depression. Secretion of the pituitary gland increases producing an increase in prolactin and cortisol (Zuehlke, 2008). Additionally, the increases in estrogen and progesterone levels during pregnancy normally reduce after the baby is born. The thyroid gland may increase in some women after pregnancy causing hyperthyroidism or hypothyroidism, in some cases (Zuehlke, 2008). This form of thyroid dysfunction leads to depression.

Signs and symptoms of postpartum depression

Postpartum depression represents a major depression incident. One of the symptoms experienced by women with postpartum depression is a disconnection from feelings or emotions. The women show high levels of fatigue, fear, and sadness. According to Kleiman (2008), the women may also show insomnia, agitation, hopelessness, irritability, and abnormal symptoms, which may include suicidal thoughts, guilt, panic, and decreased concentration. McGarry (2012) adds that mothers suffering from postpartum depression find it difficult or may be unable to take care of the baby.

Medical Interventions

Treatment of postpartum depression includes the use of pharmacotherapies and counseling. According to Zuehlke (2008), pharmacotherapy treatment may be achieved using selective serotonin inhibitors treatment (SSRI). However, the use of medications is not advised because of the risk of medications being transferred to the breast milk. Further, prophylactic SSRIs can be used two to three weeks prior to the delivery or during delivery in patients with a past of postpartum depression (Ricciotti, Freund, and Kahan, 2004). McGarry (2012) indicates that provision of social support from family and friends is effective in reducing the psychological stressors that may be affecting the mother. Furthermore, women with postpartum depression need to attend self-help groups or group therapy. In cases where the postpartum depression symptoms are characterized by suicidal thoughts, hospitalization may be considered (McGarry, 2012). Additionally, electroconvulsive therapy may also be used in such severe cases.

Prognosis

In women with a past of postpartum depression, the recurrence of the condition is high at 90 percent. According to Ricciotti, Freund and Kahan (2004), prophylactic SSRIs can be started prior to or during the delivery of the baby. Early treatment of postpartum depression results in better prognosis. Additionally, the interaction between the mother and the baby is negatively affected by postpartum depression. If depression is untreated, there is likelihood of the child developing social, behavioral, and emotional problems. The child may also experience cognitive development problems. Further, if left untreated for a long period, more time will be required for treatment to be effective (McGarry, 2012).

Assessment

Assessment of postpartum depression can be done using three instruments. These include the use of the Bromley Postnatal Depression Scale (BPDS), Postpartum Depression Screening Scale (PDSS), and the Edinburgh Postnatal Depression Scale (EPDS) (Sierra, 2008). The EPDS uses a self-report questionnaire that measures the cognitive and emotional symptoms of postpartum depression (Sierra, 2008).

Implementation

While under treatment, the mother needs to be encouraged to raise and take care of herself and the baby. Isolation from other individuals needs to be minimal, adequate rest is required and the mother needs to spend time alone with her partner (Lehne, 2012). When using pharmacotherapies, initial dosages need to be low to minimize the side effects that may be develop

due to the medications. Treatment needs to be continued for at least six months after the symptoms have disappeared to prevent relapsing (Lehne, 2012).

Nursing Diagnosis

Criteria used for the diagnosis may involve the DSM IV criteria for major depression that occurs within four weeks after delivery. Tests need to be conducted to ascertain that conditions such as anemia and thyroid abnormalities are absent. According to Ricciotti, Freund, and Kahan (2004), lab tests include thyroid function test and CBC (complete blood count test).

Evaluation

Evaluation is based on the Edinburgh Postnatal Depression Scale. A score of 12 or more on this scale indicates the probable presence of postpartum depression and this necessitates the need to have thorough evaluation

Planning

Screening for the conditions increases detection rates. Thus, more effort and resources need to be used to ensure that mothers are checked for possible likelihood for postpartum disorder. Male partners also need to be involved to ensure that the mother has the social support needed.

References

Ricciotti, H. A., Freund, K. M., Kahan, S. (2004). In a page, OB/GYN & women's health. Malden, MA: Blackwell Pub.

Kleiman, K. (2008). Therapy and the Postpartum Woman: Notes on Healing Postpartum Depression for Clinicians and the Women Who Seek Their Help.

New York: Taylor & Francis.

Lehne, R. A. (2012). Pharmacology for nursing care. St. Louis, Mo: Elsevier/Saunders.

McGarry, K. A., & Tong, I. L. (2012). The 5-minute consult clinical companion to women's health. Philadelphia: Wolters Kluwer/Lippincott Williams & Wilkins Health.

Sierra, J. (2008). Risk Factors Related to Postpartum Depression in Low-income Latina Mothers. MI: ProQuest.

Zuehlke, J. B. (2008). Traditional and Non-traditional Techniques for Women with Postpartum Depression: An Integrative Group Treatment Manual. MI: ProQuest.