

Effectiveness of treatment of postnatal depression



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But there have been a recent number of studies that looked at the effectiveness of treatment of postnatal depression. From one of the most recent publications (Dennis, 2005) provides a meta-analysis of the factors which influence the outcome in the condition. The author concluded that the only strategy that was shown to have “ a clear preventative effect” was intensive post-partum support from the healthcare professionals who are involved in the care of the mother. Surprisingly, this was found to be more effective than all the similar regimes which included an ante-natal component as well.

A stable family life, a person experiences in the first years of life have profound effects on his or her mental health. On the other hand, talking about postnatal depression also have to concerns about the lives of the babies involved. A child from a stable home, looked after by affectionate, caring parents (or other adults), is likely to be mentally stable and able to resist everyday stresses than a child from a home where there is emotional strife, constant bickering or violence this child is more at risk of developing a personality disorder in later life. Although one in four of the population in the UK will suffer from a mental health problem at some point in their lives regardless of age, race, gender or social background. Anxiety and depression for an example in post-natal women is fairly common (Fowles, 1996).

Postpartum depression is considered as a factor which can affect the development of a child in the early period of his or her life and partly determines the childs future. The morbidity associated with postnatal

depression has a number of potential consequences not only for the mother, but also the child and the rest of the family as well (Oakley et al, 1996).

Several recent studies have shown that healthcare professionals often fail to spot the signs of postnatal depression. Making the diagnosis is obviously the prerequisite of establishing a treatment regime so it is clearly vital for all healthcare professionals to be on their guard for warning signs - sleep disturbance, irritability, mood swings and irrationality (Ramsay et al, 1995).

The importance of spotting the signs of postnatal depression is stressed in the National Institute of Clinical Excellence clinical management and service guidance on antenatal and postnatal mental health, which was released lately that it is applicable to healthcare professionals who care for women who are designing a pregnancy, are with child or throughout the postnatal period (the first year after giving birth) (NICE, 2007). According to NICE, it is approximated that as numerous as one in seven women experience a mental health disorder in the antenatal or postnatal period (Hagen et al, 2007). The guidance is the first of its kind to make exact recommendations on identification, treatment and management of all mental health disorders, encompassing disquiet, depression, consuming disorders, bipolar disorder, schizophrenia and obsessive-compulsive disorder. It should be read in conjunction with living NICE guidance on mental disorders.

The guidance states that service users with a mental health disorder should be granted heritage perceptive data at each stage of evaluation, diagnosis, course and treatment about the influence of the disorder. This data should cover the appropriate use and probable side-effects of treatment (Harris,

1994). This recommendation concerns to women with a living mental health disorder who are with a child or planning for a pregnancy, and those who evolve a mental health disorder throughout pregnancy or the postnatal period.

Healthcare professionals should work to evolve a believing connection with the woman, and her partner(if they have one), imidiata family members and carers where appropriate and agreeable to the woman. In specific, they should be perceptive to the matters of stigma and disgrace in relative to mental illness (Harris, 1994).

Stigma as defined by Abrams et al, (2005) is “ a mark or sign of disgrace or discredit”.

Stigma causes people to feel uncomfortable around an issue, or can also cause people to mock the issue in order to make it less threatening to them. Most people who feel uncomfortable is often refused to talk about mental illness therefore causing a silence around the subject. People usually tend to attach stigma to others that are different from them. Often, due to mistaken beliefs, the mentally ill are thought to be dangerous. The stigma attached to mental illness is the main obstacle to better mental health care and better quality of life for people who have the illness, for their families, for their communities and for health service staff that deal with psychiatric disorders (Abrams et al, 2005).

Routine communication with doctors and healthcare professionals throughout pregnancy and the postnatal period presents an opening to recognise women who have, or are at risk of evolving, a mental health

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disorder. At a woman's first communication with professionals in both antenatal and postnatal periods, doctors and healthcare professionals should enquire about: (Hagen et al, 2007).

- Past - Previous treatment and medication by a psychiatrist or expert mental health group, encompassing inpatient care;
- A family history of perinatal mental illness.

However, the guidance stresses that other exact predictors, for example poor connections with her colleague, should not be utilised for the usual proposition of the development of a mental health disorder (Gotlib et al, 1991).

The following questions must be asked when a pregnant woman attend to a health care professional;

- During the past month, have you often been bothered by feeling down, depressed or hopeless?
- During the past month, have you often been bothered by having little concern or delight in managing things?

If the woman responses ' yes' to both of these questions, a third enquiry should then be considered:

- Is this certain thing you seem you require or desire assistant with?

The use of self-report assesses for example the Edinburgh Postnatal Depression Scale (EPDS), Hospital Anxiety and Depression Scale (HADS) or Patient Health Questionnaire-9 (PHQ-9) may be advised as part of a later evaluation or for the usual supervising of outcomes (Harris, 1994).

If a likely mental health disorder is recognised throughout pregnancy or the postnatal period, a further assessment will be needed:

- If the woman has or is supposed of having a critical mental sickness (for demonstration bipolar disorder or schizophrenia), she should be mentioned to a mental health care service, encompassing, if appropriate, an expert perinatal mental health service professional (Hagen et al, 2007).
- The woman's GP should be acquainted in all situations even if no further evaluation or referral is made (Hoffman and Drotar, 1991).

And in writing care plan covering the pregnancy, consignment and the postnatal period should be evolved for with child women with a present or past history of critical mental sickness, generally in the first trimester. This should be evolved in collaboration with the woman and her colleague, family and carers, and encompass expanded communication with mental health service professional (Fowles, 1996).

The guidance suggests there should be apparently particular care pathways so that all applicable prime and lesser healthcare professionals understand how to get access to evaluation and treatment (Hoffman, 1991).

NICE states that there is clues to support the use of aimed at psychosocial interventions for women who have symptoms of depression and/or disquiet that manage not rendezvous the threshold for a prescribed diagnosis. The guidance interprets that certain treatment or support for a postnatal woman should be advised when symptoms manage not rendezvous diagnostic

criteria but ' significantly hinder with personal and communal functioning' (Hagen et al, 2007).

For this assembly of women the following should be considered:

- Offering one-to-one, short psychological treatment (four to six sessions), for example interpersonal psychotherapy or cognitive behavioural treatment for mental health service users who have had a preceding episode of depression or anxiety;
- Offering communal support throughout pregnancy and the postnatal period (such as normal casual one-to-one or group-based support) for women who have not had a preceding episode of depression or anxiety (Fowles, 1996).

However, it adds that psychosocial interventions conceived expressly to decrease the prospect of evolving a mental health disorder should not be part of usual antenatal and But it adds that treatment conclusions are perplexing by the occurrence of the evolving foetus, breastfeeding and the timescales enforced by pregnancy and birth (Hagen et al, 2007).

As an outcome, it contends that the thresholds for non-drug treatments, especially psychological treatments, ' are probable to be smaller than those set in NICE clinical guidelines'.

It emphasises that women who require psychological treatments should be glimpsed for treatment commonly within one month of primary evaluation and no longer than three months afterwards (Goodman, 2004).

The NICE guidance summaries the function doctors can play in noticing, stopping and nurturing for women with a mental health disorder when planning for a pregnancy, throughout pregnancy and the postnatal period. Mental health promotion becomes very important for the people who are planning to have a child or those who are already pregnant or newly born mother. It should be mentioned that postnatal depression is possible to occur but they should be aware that it is treatable (Harris, 1994).

When in a clinical setting dealing with a patient with a mental illness, it is good practice to communicate effectively and adjust the skills accordingly to the patient. For example speak clearly, slowly and ask open-ended questions. Observing any change in mood and behaviour at all times for safety reasons.

REFERENCE

Cox, J., Holden, J., & Sagovsky, R. (1987) Detection of postnatal depression: Development of the 10 item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry*, 150, 782-786.