Free research paper on postpartum depression

Technology, Development

Post-Partum Depression

For every women blessed with children, nothing is more fulfilling than giving birth to the child and filling them with love and hope. Emotions are high at best, especially with pregnant women as they can easily become depressed or frustrated, depending on their mood swings. While some mothers tend to become happy and elated upon the birth of their children, a few tend to become distressed and moody due to various factors and influences. Although it could be understood that these worries have some ground, especially for new mothers and even fathers, some parents may find themselves overcoming this depression especially if they have financial issues, intense mood swings, and high levels of stress throughout the pregnancy period up to the birth. Research note that this is not regular depression if the pregnant woman exhibits tell-tale signs of sadness, insomnia, mood swings, and anxiety; instead, this case can be considered a sign of postpartum depression.

There is no clear history as to when and how postpartum depression began. However, Lee (2004) noted that sometime around the 1950s, the idea of postnatal depression or postpartum depression is a recent addition in the field of psychiatry. In the period alone, PND/PPD was not used as a term to refer to an atypical behavior of pregnant women of childbirth, which was then known as postpartum psychosis. Postpartum psychosis was first noted in ancient Greece and was reanalyzed sometime in the 19th century. However, while the atypical behavior changes have been identified, there was still a small discussion as to how close the relationship of both motherhood and mental illness. Many experts have varied as to when

PND/PPD was recognized in the period. According to Katharina Dalton, who is known foremost with her book on PND/PPD, both puerperal psychosis and postpartum psychosis were recognized before the 1950s, which then implies that many accepted that only a few mothers would develop severe mental illnesses after childbirth. Whenever there were women who are reported to have a mild kind of psychological condition, it was often called “ baby blues”. Although the phenomenon was not yet considered a mental illness, it was a noted fact that baby blues is a side-effect of child birth.

The interest of the psychiatrists and experts suddenly turned in the 1960s as they saw signs that motherhood is indeed contributing to the increase of mental ill health problems. According to Ian Brockington, a psychiatrist who wrote about various mental illnesses and motherhood, noted that there were already signs that people are acknowledging the presence of postpartum depression or PND in the period. Several studies have showcased this, such as the one done by Pitt in 1968, which showed various categories of postnatal depressions. Pitt’s study also became a foundation to the study of PND as it revealed that “ Depressive neurosis” is present in 10% of women, and it varies from the psychosis found in women. Therefore, their symptoms are different from those people with depressive neurosis. The study also noted that psychotic women tend to have hallucinations or delusions, but they share an instance of depression that is both startling and unusual.

According to the World Health Organization (2003) postpartum depression affects up to 34% of new/old mothers alike and would often appear in the first few weeks or months of childbirth. Sometimes, it is noted to persist for a year or more, depending on the treatment undertaken by the patient or if it

is not treated. While depression itself is sometimes considered the main symptom of PPD/PND, it is not always the case. Sometimes, PPD/PND can be mistaken for other types of postpartum depression instances. According to Kripke (2012), however, postpartum depression or postnatal depression tends to cause patients to feel overwhelmed in most periods which would not easily go away without reassurance. PPD/PND patients also tend to feel regretful over their capability to become a mother, as well as sustain their babies. There are also suicidal tendencies with PPD/PND mothers, especially to their babies and themselves. They also tend to isolate themselves from others, especially as they tend to feel a lack of motivation with regards to connecting with others. Aside from this, PPD/PND patients tend to also feel as if they are not good mothers, and would not be able to hold the child because of the feeling that the baby does not love or like the mother. There is also the never ending feeling of sickness or incapacity that makes these people feel they are not capable of themselves or feel well at all. Patients also tend to exhibit signs of vulnerability which could last for more than 2-3 weeks.

In comparison, normal depression or postpartum blues tends to exhibit signs of fantasies of running away from the responsibility, but would eventually forego the feeling once the baby is rested and taken care of. There is also the recurrence of fatigue from taking care of the baby and some bouts of isolation, but this would be the result of spending time with the child. Normal depression also tends to show signs of body aches and pains which are caused by childbirth or feeding. Most of the feelings of normal depression also showcase vulnerability; however, these feelings will go away and would

not affect one’s perspective of themselves . PPD/PND is also different slightly to Postpartum Psychosis, which is noted to be rarer than PPD/PND. According to Littleton and Engebretson (2005) patients of postpartum psychosis tends to occur in 1or 4 of every 1, 000 births per year. It also begins in the first 2 weeks of childbirth. In this end, women with bipolar disorder or other mental health conditions are at risk to postpartum psychosis. Both PPP and PPD/PND share similar symptoms such as insomnia, mood swings, eating disturbances, confusion and even poor judgment. However, according to Williams (2010), patients with PPP tend to see things that are not there, feel immense confusion over specific topics and uses, and even have the highest tendency to commit pain and hurt their babies and themselves. Delusions of PPP patients tend to revolve around God and the devil. Treatment is also different as PPP is more life threatening than PPD/PND as it may lead to the patient’s death through suicide or even the crime of infanticide. Similar to PPD/PND, PPP can also be treated through hospitalization, antipsychotic medications and psychotherapy .

According to Miller and LaRusso (2011) early identification of women who are at risk to PPD/PND is essential to ensure that the problem could be prevented, as well as ensure the woman’s safety. Westall (2011) noted that early detection of PPD/PND is difficult as some women tend to hide their distress and worries. Some of them tend to also mask their depression, making diagnosis difficult to do since these mothers would feel worthless and even shame of being called “ bad mothers”. In some cases, women tend to hide their dilemma for the very reason they fear that their children will be removed from their care once it is discovered they have PPD/PND. Patients

with PPD/PND also tend to refuse to seek help, feeling that it would end shortly and due to the costs of treatment. Nonetheless, for detecting PPD/PND, health professionals can use a biopsychosocial model of health to determine if the patient has psychiatric illnesses instead of using screening tools. An interview is an excellent model used by practitioners to check PPD/PND development. Patients are asked of their history, their mental status, laboratory tests, and the use of the DSM-IV-TR system to rule out other mood disorders to diagnose the patient. While screening tools could also be used for determining the development of PPD/PND, there is a debate as to how capable it is to determine the onset of PPD/PND and if it is also capable of preventing the problem. Currently, the Postpartum Depression Predictors Inventory is currently waiting validation trials with various psychological organizations to check if it could detect antenatal and postnatal periods of mothers and prevent PPD/PND .

Risk factors attached to PPD/PND have closely been examined by experts from the woman’s genetics, hormonal and reproductive history, and also the woman’s life experiences, which may foster depression and stress to develop strongly. From the research, biologic factors that are closely associated with PPD/PND are those who experience depressed moods or anxiety during pregnancy, those who have a past history of depression or premenstrual dysphoric disorder, and those from families with histories of depression and anxiety. For the psychosocial factors, people are at risk to PPD/PND if they have a history of stressful life events and if they lack social support from their peers, families, and colleagues. Other factors could also attribute to PPD/PND like the woman’s socioeconomic status, low self-esteem issues

(especially if the parent is somewhat uncertain over her parenting skills), negative birth experiences or obstetric complications (if the woman had already given birth), traumas on handling infants, and finally, if the pregnancy is unplanned or unwanted. Experts also note that another possible risk factor for PPD/PND is the availability of social support or practical assistance once the child is given birth . Clark (2010) added that recent change in marital status, history of childhood abuse or rape, as well as a history on perfectionism and inability to ask for help is also a risk factor to PPD/PND patients. He also added that having just one of these risk factors does not necessarily mean the patient would actually contract postpartum depression. However, knowing these risks helps women to prevent developing the problem .

Given the risk factors of PPD/PND, women who are at risk to PPD/PND tend to showcase symptoms through their actions. According to Wisner, Parry, and Piontek (2002), the number one symptom of PPD/PND is major depression, which manifests themselves within four weeks after delivery. Women with PPD/PND tend to showcase depressed moods, which is often with severe anxiety and stress. Patients with the disorder also showcase a diminished interest on activities, pleasure, and fun; declining even in food and sleep. With this, patients tend to exhibit signs of appetite disturbance and weight loss, including insomnia and fragmented sleep. This may even cause problems when taking care of their children. Women with PPD can also be easily agitated and in some cases, exhibit psychomotor slowness that prevents them from thinking clearly and decision making. They also tend to tire easily and exhibit feelings of worthlessness and lack of self-worth. In

some cases, patients with PPD/PND tend to even feel suicidal or commit similar psychological tendencies . In addition to this, PPD also causes women to cry uncontrollably and even harm themselves due to depression and anxiety .

There are several postpartum depression prevention and treatment strategies noted to ensure that PPD/PND are prevented and remedied for mothers especially after childbirth. Generally, PPD/PND patients are required to undergo psychological counseling to ensure that the patient’s degree of depression and anxiety is high and to answer some inquiries regarding the problem. It would also enable both the patient and their families as to how to cater to psychological support and practical help to the patient, especially to ensure that the child is taken care of by their families. Families are also advised to listen to the needs of the patient, as they would require constant encouragement and support to understand their situation, as well as to also assist them in embracing their motherhood. Support groups are also available for patients to take part in, which would often discuss as to how others recovered from their experiences and share tips as to how to assert themselves to undergo treatment for PPD/PND. Experts also note that these patients should be taken to the hospital and to a specialist once doctors diagnose these patients as it is noted that they may also develop signs of postpartum psychosis.

According to McCoy (2011) and Moore and Puri (2012), since universal screening for PPD/PND, many cases of PPD/PND go undetected and untreated. While it resolves by itself within a few months after the symptoms, it is still harmful for both the mother and the child. One of the

noted treatments to PPD/PND is the interpersonal psychotherapy or IPT, which is noted to be the most effective intervention treatment for PPD. The IPT consists of studies which would constitute in discussing the relationships and the plausible counters to relationship disruptions as it can cause high depression instances. Problems in broken and unsteady relationships are also resolved through IPT. Studies have noted that those who have gotten these treatments tend to score lower on their depression tests. IPT is also noted to be capable of reducing depressive symptoms overtime as compared to other treatments. It is also the first line of treatment by patients of PPD/PND to use as it does not have a side-effect on their body. IPT also is capable of addressing interpersonal issues, like role change and life stressors, which would be crucial while the woman is under their postpartum period. There is also the Cognitive behavioral therapy, which is combined with other types of psychotherapies for PPD/PND patients. Under the CBT, patients are educated in restructuring their negative thoughts and perspectives regarding themselves, the world around them, and everything they could possibly ask about, like the future. CBT also covers problems which may cause depression and reduce the risk of further PPD/PND instances.

Some patients are also advised to either take double-blinded tests and antidepressant medication to aid in the problem. When it comes to double-blinded, placebo-controlled studies; patients with transdermal estrogen are noted to easily be treated of PPD/PND. Antidepressant medication is also a noted treatment for PPD/PND, such as selective serotonin re-updates inhibitor sertraline and anxiolytics. Sertraline is safe for lactating women as it

does not transfer toxins and other chemicals to the infants. Some patients also note that they take in paroxetine and nortriptyline, which also produces the same effect to reduce the depressive symptoms patients tend to exhibit. Sleep and exercise is also noted to be an effective treatment for PPD/PND. When it comes to managing sleep, patients are advised to use blue-blocking light bulbs and glasses at night or to work on with their children at low light. Experts note that it is an excellent means to reduce mood dysphoria. In terms of exercise, patients are advised to try out aerobics or exercises that could bring out endorphins, which would aid in improving well-being. Some studies have also noted that being physically fit increases self-esteem and achievement since the patients would lose body weight and improve their health. It is also a beneficial distraction for patients since it could improve their body and esteem. Massage is also noted to be an excellent treatment for PPD/PND as it allows women to relax and improve control . Some patients are also advised to take preventive treatment to prevent further development of PPD/PND . Having someone stand in with the patient during labor is also seen as a perfect means to alleviate the problem of PPD/PND. When it comes to the prognosis of recovery, experts firmly stress that if done correctly, PPD/PND can easily be treated and recovery is assured. Patients with postpartum blues make fast recovery, while those with PPD/PND tend to have various ranges of recovery. If the patient has been immediately diagnosed of PPD/PND and was treated immediately, prognosis would be good. There is also a high chance of recovery within a year when it comes to PPD/PND patients . However, as noted by Stone and Menken (2008) patients with untreated PPD/PND, may tend to showcase emotional problems as they

would have impaired mother-infant interaction and detachment. They also would develop instances of emotional instability and impaired understanding and discussions with their love ones and friends. Children who have untreated PPD/PND mothers also develop signs of childhood depression, which may also result into PPD/PND of these children once they come of age. Conduct disorders are also plausible to children with PPD/PND mothers, including school and communication problems. In some studies, some children with PPD/PND mothers tend to develop behavioral problems at 4 years old . There is also a high possibility of recurrence when it comes to untreated mothers, which may lead to psychosis relapse in the future, and the development of postpartum psychosis, which would be severe in intensity once it is developed.

While many would find themselves depressed to the new chapter of their family life, it is important to remember that one will always find support wherever she may be. Postpartum Depression tends to be fatal and recurring if not immediately treated or acknowledged. It is also an advice to mothers, both for those who have not contracted the disorder and those who have gotten it before, to remember that postpartum depression strikes without warning which is why research showcases that while there are people who contract this problem, it is not always the same case for others. For family members and love ones of PPD/PND patients, it is important to shower them with love, and support as they would need all the support they could get to recover from the ordeal.

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