

Understanding of Postpartum Depression; Mini Literature Review

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ABSTRACT

The transition to motherhood is a life-changing event that can be stressful, influencing a woman's mental health and well-being. Postpartum depression (PPD) is a mental health concern affecting mothers, infants, and fathers from diverse backgrounds. Fifty to sixty percent of new mothers experience initial sadness and postpartum blues due to hormonal changes. Prenatal nurses often overlook PPD during postnatal visits due to a lack of knowledge and decreased self-efficacy when assessing and educating mothers about PPD. This is a mini systematic literature review.



Keywords

Postpartum depression, Mental health, Motherhood.

Introduction

Background

In the United States, one in seven women develops postpartum depression (PPD) after giving birth. According to Wang et al. [1], PPD occurs in 17.22% of the world's population. In western countries, the prevalence rate is 10-15%, and individuals residing in low-middle-income countries experience a higher prevalence rate of 18.66% [1]. Postpartum depression is a mental health concern affecting mothers, infants, and fathers from diverse backgrounds. The transition to motherhood is a life-changing event that can be stressful, influencing a woman's mental health and well-being. As a result, women become more vulnerable to mood disorders such

as PPD [2]. Postpartum depression occurs as early as four weeks postpartum.

Many nurses mistake PPD for postpartum blues as a normal "feeling" among new mothers. Postpartum blues occurs when mood changes begin within the first few days postpartum and may continue for weeks and or months. Fifty to sixty percent of new mothers experience postpartum blues due to hormonal changes [3]. Although many women experience postpartum blues after childbirth, women tend to recover quickly compared to PPD. Postpartum depression lasts longer and severely affects a women's health and well-being. According to Hahn et al. [3], new mothers are often undiagnosed because PPD is overlooked during postnatal visits. Perinatal nurses lack knowledge and self-efficacy when assessing for PPD in new mothers. As a result, patients experience

decreased patient education [4]. By increasing nurses' knowledge regarding PPD, nurses will gain the confidence needed to educate patients and families.

Theory

Cheryl Beck's [5] Postpartum Depression Theory was utilized to guide this systematic literature review. Beck's theory provides insight into the different challenges women experience, signs and symptoms, and risk factors associated with PPD. Beck's Postpartum Depression Theory describes major postpartum mood disorders concepts [6]. Beck defined PPD as a major depressive disorder that occurs as early as four weeks postpartum [7]. Signs and symptoms associated with PPD include lack of energy, feelings of inadequacy, loss of interest, and inability to love the infant adequately. Maternal blues or postpartum blues was defined as mood changes that begin within the first few days postpartum [7]. Beck also defined severe psychotic postpartum mood disorders that can occur postpartum such as postpartum psychosis, postpartum obsessive-compulsive disorder, and postpartum panic disorder. Postpartum Depression Predictors Inventory (PDPI) and Postpartum Depression Screening Scale (PDSS) are the ideal tools to be used by health care providers. Beck's PDSS incorporates risk factors and predictors used to screen for PPD symptoms in women [8]. The Postpartum Depression Screening Scale is a Likert-self-report scale that includes eight concepts. The eight concepts include sleeping and eating disturbances, anxiety and insecurity, emotional lability, mental confusion, loss of self, guilt and shame, and suicidal thoughts.

Mini Literature Review

A review of nursing and health-related literature was conducted to explore PPD signs and symptoms, risk factors, screening tools, and treatment options using the following keywords both singularly and in multiple combinations: postpartum depression, risk factors, and lived experience. Electronic research databases such as the Nursing and Allied Health Database ProQuest, CINAHL Plus with Full Text, EBSCO, and Google Scholar were searched and limited to the years 2018-2023. The 5-year limit was used to ensure current evidence-based literature is reviewed and summarized.

Postpartum Impacts Moms

A recent meta-analysis study conducted in 56 nations resulted in a global PPD prevalence rate of 10% to 20 % affecting mothers in rural communities in both high-income and low-income mothers [4,8]. Adjusting to motherhood is a life-changing event that can sometimes be stressful, resulting in increased vulnerability to the development of psychiatric mood disorders after childbirth [9]. Postpartum depression is a major depressive disorder that often develops 4-6 weeks postpartum and can significantly affect mothers and their families [10]. Mothers diagnosed with PPD often experience physical, emotional, and behavioural changes such as depressed mood, sadness, anxiety, irritability, and anger. Hopelessness, diminished interest, worthlessness, and lack of sleep are evident. Mothers suffering from PPD also experience decreased parent-child bonding, weight changes, difficulty concentrating, and changes in appetite. Untreated or unrecognized PPD leads to

increased health risks in mothers such as poor nutrition, increased substance use, and maternal suicide [11].

Postpartum Impacts Dads

Males are often described as "invisible victims" although research shows a higher rate of depression in males. The prevalence rate of depression in men with partners facing PPD is 24% to 50%. Parental depressive symptoms also occur in 14.1% of men in the United States versus 8.2% internationally [12]. Fathers often report feelings of isolation, suffering from mutual symptoms, and a lack of understanding concerning PPD. Another study composed by O'Brien et al. [13], used a qualitative couple-focused approach to gain an in-depth understanding of the couple's experiences related to PPD. Participants were recruited from the western United States through online and community advertisements. Fathers that play a supportive role reported feelings of frustration, doubt, increased stress, and engagement in violent behaviours. Three distinct patterns were identified in the study: dismissal, acknowledgement and accommodation. Dismissal referred to fathers feeling a need to protect mothers from judgment. Acknowledgment referred to the father's ability to open up about their concerns and receive help. Accommodation referred to a trial and error process that couples undergo to find coping strategies. Both studies suggest that healthcare providers need to extend focus from a mother-infant perspective to a family-focus perspective [12,13]. A study by Eddy et al. [14] supports the need for a change from individual-focused to family-focused because many fathers experience PPD.

Postpartum Impacts Babies

According to Brownlee [11], untreated or unrecognized PPD affects infants. Mothers diagnosed with PPD tend to discontinue breastfeeding earlier and show less warmth and sensitivity toward their infants, resulting in decreased mother-infant bonding. The decrease in mother-infant bonding negatively affects the infant by causing cognitive and social developmental delays, low birth weight, diagnosis of attention deficit, anxiety, and depressive disorders. A study conducted by Urizar et al. [15], examined the relationship between maternal depression and childhood development among low-income children. Results of the study revealed decreased child cognitive development in children with mothers experiencing depression.

Culture and Postpartum Depression

Various research studies examined cultural factors in relation to PPD. Culturally; First Nation American women desire to be "good mothers" and are more connected to their heritage-related practices during the perinatal period [16]. First American mothers are taught culturally to only seek advice from their mothers or grandmothers regarding antenatal and postnatal concerns, and not health care providers. Mothers from Native America also prefer to model mothering behaviours seen when they were younger. A recent study conducted by Han et al. [17], also examined cultural factors in relation to PPD. The study used a qualitative exploratory design to conduct a study on eleven Korean women diagnosed with PPD. The study suggests that Korean women are one of the six largest Asian American subgroups and are often less likely to

report symptoms of PPD compared to other race-ethnic groups. The cultural concept of “saving face” is prevalent in Korean culture and refers to preventing severe shame and dishonour to the family. Korean women practice various postpartum traditions such as Sanhoo-Joeri. Sanhoo-Joeri includes practices such as keeping the body warm, drinking seaweed soup to boost circulation, and using Korean maternal recovery homes to result in holistic maternal health [17]. Although the study participants lived in the United States for several years they continue to desire traditional Korean postpartum care. Nurses need to be aware of the various cultural factors influencing PPD and work toward providing culturally competent care ([17]. A study by Park et al. [18] supports the need for healthcare professionals working with Asian American women to incorporate culture-specific traditions to aid in culturally competent care. Chinese Americans represent the largest Asian American subgroups and are less likely to report symptoms associated with PPD. The authors conducted a qualitative study on 15 Chinese American women about PPD and mental health help-seeking behaviours. Results of the study revealed that Chinese Americans are less likely to be diagnosed with PPD due to stigma and cultural barriers [18].

Barriers to Mental Health Help-Seeking

According to Grissette et al. [19], only 6% of women experiencing PPD symptoms seek professional psychological help. Women who do not seek help are at greater risk of death from suicide. Women from diverse backgrounds are reluctant to seek professional help due to stigma, lack of knowledge, and healthcare system barriers surrounding mental health [17]. Mothers diagnosed with PPD face both cultural and social stigmas. Social stigma includes a societal belief that motherhood “should” be happy during this time and should “snap out of it”. Cultural stigma includes; Frist American woman describing PPD as a “very taboo topic” [16]. Fathers also experience potential stigma related to depression and are less likely than women to seek professional help for depression. Fathers feel pressured to take up the traditional “tough guy” stereotype. As a result, fathers are reluctant to share their experiences and feelings because they do not want to look weak to their wives [20]. Stigma creates increased barriers to seeking PPD support due to the fear of judgment from family, friends, and providers [19].

Jones [21] studied postpartum women's attitudes toward professional mental help seeking in relation to stigma and mental health literacy. Participants were recruited from social media, and data was analyzed using hierarchical linear regression. Results indicated that stigma resulted in decreased mental health seeking. Mental health literacy resulted in increased mental health seeking. Therefore, reducing stigma is essential to aid in increased mental health seeking during the postpartum period.

Risk factors associated with PPD

Various studies show a variety of risk factors associated with PPD. Risk factors include low socioeconomic status, unintended pregnancy, hormonal fluctuations, loss of baby, sex of the baby and a history of depression [16]. Individuals experiencing a lack of social support and antenatal depression/anxiety are at greater risk

of developing PPD [16]. A prospective study examined PPD risk factors in 300 women during pregnancy and after childbirth using questionnaires. The study found that 245 women had scores above the cut-off point greater than 13 on EPDS. Researchers observed high scores in women who experienced complications during and after pregnancy and were more prone to the development of PPD.

Postpartum Depression

Screening: According to Çankaya [22], maternal and infant mortality rates for individuals diagnosed with PPD is increased. The American College of Gynecologists and Obstetricians recommends screening for PPD during postpartum visits [23]. Women have one postpartum visit six weeks after delivery, although PPD can occur at any time postpartum. Therefore, pediatric health providers should screen mothers during 1,2,4, and 6-month pediatric well-child visits [11,23]. Incorporating PPD screening in pediatric care aids in health promotion and early dedication [23].

Fathers are often missed during screening for PPD, nurses must assess both mothers and fathers during postpartum visits [12,13]. Screening for PPD should include both objective and subjective assessments. Subjective assessments allow clients to express their experiences and concerns. Objective assessments use scales such as the EPDS and Postpartum Depression Screening Scale (PDSS) [23]. These scales can be easily administered and commonly used to measure depressive postpartum symptoms. EPDS is an appropriate measuring tool for PPD in both mothers and fathers. The EPDS scale aids in the early dedication of PPD symptoms and timely interventions [11,23].

Edward et al. [20] conducted a single-blinded randomized controlled study to test self-screening tools (EPDS) and referral pathway pamphlets for women and partners. Researchers handed out envelopes unaware to the intervention group (referral pamphlet and screening tool) and control group (no pamphlet and screening tool). The result indicated that self-screening tools and pamphlets given to couples during the prenatal period can aid in early dedication and increase mental health help-seeking [20].

Postpartum Depression Treatment

An article composed by Limandri [8], studied treatment options for supporting women and families experiencing PPD. Pharmacological interventions include tricyclics, noradrenergic dopaminergic reuptake inhibitors, and selective serotonin reuptake inhibitors are found to be effective when treating PPD [8,24]. Repetitive transcranial magnetic stimulation such as electroconvulsive therapy can also be used in treating moderate to severe PPD [2].

Non-pharmacological interventions were found to be more common when supporting mothers diagnosed with PPD. Supportive care, partner education, support groups, educational materials, and peer support sessions are examples of non-pharmacological interventions used by healthcare professionals [8]. Alternative therapies such as yoga, aromatherapy, and massage can be used in conjunction with traditional practices to elevate PPD symptoms

[2]. In addition, psychological interventions such as interpersonal therapy and cognitive behavioural therapy (CBT) can also be used to treat PPD [2,24].

A study by Van Lieshout et al., [25] conducted a randomized control study. The study examined mothers in Ontario, Canada with infants less than 12 months and mothers with EPDS scores greater than 10. Public health nurses provided the experimental group with two hours of in-person sessions of CBT. The study results revealed improvement in the experimental group. Therefore, cognitive behaviour therapy provided by public health nurses resulted in increased patient outcomes [25]. Another study by Van Lieshout et al., [26] supports the effectiveness of CBT in reducing PPD symptoms. The authors conducted a randomized control study and recruited 403 participants located in Ontario, Canada diagnosed with PPD. Participants' inclusion criteria included EPDS scores of 10 or greater, and infants less than 12 months. Women were randomly selected to receive regular treatment and placed on a 12-week workshop waitlist (n=201) or standard treatment and an online 1-day CBT workshop delivered by a psychotherapist or psychiatrist (n=202). Results of the study revealed a significant reduction in EPDS scores in participants who received treatment together with an online workshop [26].

Nursing Interventions and Recommendations

Nurses and healthcare providers must incorporate PPD education into discharge teachings and postpartum visits [12]. Patient education is essential to reduce EPDS scores and allows for an open dialogue about stigma [19]. Mothers and fathers from various cultures may not understand the differences between hormonal changes and PPD symptoms. Fathers tend to turn to internet sources for knowledge regarding PPD [12]. Lack of knowledge regarding PPD is a barrier to diagnosis and treatment. Therefore, nurses should also aim to provide perinatal education that includes fathers [13]. In two similar studies, Lewis [10] and Link et al. [4] revealed that prenatal nurses play an essential role in providing postpartum depression education. Nurses often do not provide education due to a lack of knowledge about PPD. Both studies also found a relationship between nurses' self-efficacy related to PPD teaching. To increase confidence levels nursing leaders' support is needed as opportunities for current knowledge regarding PPD. Nursing leaders must promote increased PPD knowledge achievement for nurses to successfully implement PPD patient education [4,10]. According to Lewis [10], limited studies have addressed the relationship between nurses' knowledge and the practice of patient PPD education.

Conclusion

Many nurses mistake PPD for postpartum blues because baby blues is deemed normal among new mothers. Postpartum blues occurs when mood changes begin within the first few days postpartum. PPD affects the father and the infant along with other family members. Postpartum depression lasts longer and severely affects women's health and well-being. According to Hahn et al. [3], new mothers are often undiagnosed because PPD is overlooked during postnatal visits. Perinatal nurses lack knowledge and self-efficacy

when assessing for PPD in new mothers. Education for nurses, moms, father, caregivers, and others is essential to everyone's well-being

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