

Depression During Pregnancy: A Review

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Abstract

The role of a mother is not only physically demanding but also emotionally taxing. Women tend to have higher rates of depression and anxiety. A serious depressive episode that manifests itself during or after pregnancy is referred to as perinatal depression. It is overlooked an extremely high percentage of the time, which has a detrimental effect on the quality of life of the lady, the child, and the partner. Obstetricians have a responsibility to remain vigilant and knowledgeable about the associated risk factors as well as the screening procedures for prenatal depression. Perinatal depression that is either misdiagnosed or improperly treated can result in life-threatening consequences for the mother as well as the child. When taking into consideration the potential risks to both mother and the unborn child, cognitive behavioral therapy and medication should be administered.

Keywords: Pregnancy, Depression, Child Health, Perinatal, Behavioral Therapy

INTRODUCTION

For women, being pregnant and giving birth are extremely stressful occasions. In a very short amount of time, they experience a variety of physical and mental changes. A minority number, especially those who already have mental problems, are unable to quickly adapt to these changes. In India, an average of one in ten people experience anxiety or depression. Women who are pregnant or just gave birth make up 20% of this group.¹ Between 5 and 20 percent of pregnancies experience perinatal depression. Perinatal depression symptoms affect about 1 in 5 women. A “*Major Depressive Episode (MDE)*” that occurs during pregnancy or within the first 12 months after giving birth is referred to as perinatal depression.² The statistics are concerning, thus it's critical that all pregnant women get at least one prenatal and one postpartum screening for depressive symptoms. Early screening is crucial since perinatal depression has a number of potentially harmful effects on both the mother and the fetus. Moreover, psychological disorders, particularly sadness, are strongly linked to suicide and infanticide.^{3,4} Hence, early detection and management can stop such negative effects. Most depressed women—about 50%—never receive a diagnosis.

SCREENING IS KEY TO DIAGNOSING PERINATAL DEPRESSION

By screening patients who are pregnant or recently gave birth for mood and anxiety disorders, primary care practitioners can significantly improve the rate of detection and diagnosis. According to US studies, screening enhances outcomes for mothers who are depressed.⁵⁻⁷ The associations all advise screening for all women during the perinatal period as a result. The “*Edinburgh Postnatal Depression Scale (EPDS)*” is one of the easiest and most trustworthy screening instruments.⁸ A woman can complete the 10-question EPDS in 2 to 3 minutes in a waiting room, online, or with a clinician. It has been cross-culturally verified.^{9,10} While the EPDS includes items regarding anxiety, the Patient Health Questionnaire (PHQ9) is also a useful screening tool.¹¹ Also, it's critical to check for intimate partner abuse, which could be a factor in the patient's melancholy or even be the root of it. Pregnant women should be assessed during their first and third prenatal appointments. Postpartum women should be checked at the six-week postpartum appointment and again by the main care doctor who takes over afterward. Prenatal, postpartum, monthly well-baby, and birth classes are easy ways to contact a woman before and after she

gives birth.⁵⁻⁷ Women from lower socioeconomic status communities and members of minority groups suffer disproportionately from this misdiagnosis and mistreatment.¹² A patient who tests positive should next undergo additional clinical testing in order to be diagnosed with depression. Programs for screening should include procedures for aftercare and assistance. Also, all women who are diagnosed with perinatal depression should receive counselling to help them understand that their condition is a medical illness, that there are effective therapies available, and that having it does not make them any less of a mother.¹³

PSYCHOLOGICAL FACTORS

Perinatal depression occurs more commonly in women with anxiety. Depression is three times as likely to occur during pregnancy. Women with a prior history of postpartum depression and therapy for anxiety or depression are known risk factors for developing perinatal depression. Another significant risk factor for developing anxiety and depression during pregnancy is a history of abuse as a youngster. In fact, childhood abuse raises a person's lifetime risk of psychiatric disorder. Also, it has been suggested that prenatal depression may develop as a result of the patient's bad relationship with her parents. Moreover, substance misuse, smoking, and alcoholism make the symptoms worse.¹⁴

CULTURAL ISSUES

Social support comes in many forms. Support from other sources, such as hospitals, self-help organizations, informational support, etc., is also included in addition to familial support. Yet, the development of anxiety and depression in women is significantly influenced by their impression of their partners' lack of support. Depression during pregnancy and after delivery has several established risk factors, including a bad partner relationship, a troublesome spouse, and being alone. Another undeniable contributing element to the onset of depression is violence against intimate partners. Perinatal depression is predisposed by young age, unemployment, low socioeconomic background, and inadequate educational status. Discrimination at work and poor working circumstances have also influenced depression symptoms. Study findings among minority ethnic women have produced conflicting findings. Being a member of some minor ethnic groups, such as the Black Caribbean women, has proven to be protective.^{15,16}

DEPRESSION'S EFFECT ON PREGNANCY OUTCOME

It is understood that depression is a condition that has an impact on fetal health. Although there have been psychological and biological causes put forth, hormone theories have drawn the greatest interest. Hyperactivity of the “*Hypothalamo-Pituitary-Adrenal (HPA)*” axis has been linked to depression. Activated HPA axis peptides influence maternal mental state, which may alter birthing outcomes. The fetal growth may be negatively impacted by this elevated HPA-axis activity. In addition to activating the mother's HPA axis, maternal sadness may also increase the placental release of “*Corticotropin-Releasing Hormone (CRH)*” through the activities of catecholamines and cortisol. The possibility that CRH may possibly affect the timing and start of labor may help to explain why women who are depressed have greater rates of premature labor.¹⁷⁻²² Stress during pregnancy has been linked to HPA axis dysfunction and the resultant aberrant development of fetal tissue, according to research conducted on animals. An alternative explanation claims that depression modifies the excretion of neuroendocrine transmitters and vasoactive hormones, which causes vascular alterations in a pregnant woman. Although the body of research reveals a number of ways in which hormone imbalances may impact expectant mothers, it is still not quite apparent how depression negatively impacts pregnancy outcomes.²³ Anxiety and sadness during pregnancy and the postpartum period enhance the risk that the offspring may experience mental disease in their lifetime, according to animal studies. Bonding between mother and child is harmed by perinatal depression, which occurs at a vital moment for brain development. This affects the child's brain's morphology and physiology, which results in behavioral and neurocognitive impairments that last into adulthood.²⁴

DIAGNOSIS

A thorough history will shed light on what led up to or triggered the current depressive episode. Also, a past, present, and family history of depression and suicide must to be gathered. Moreover, information regarding past drug usage, alcoholism, and over-the-counter drugs should be gathered. The ACOG advises that the obstetrician/gynecologist or other obstetric care provider examine all women for symptoms using a validated tool at least once during their perinatal period. Just screening offers the chance to find and start care. Whooley's and the Edinburgh postnatal depression scale are the

instruments that are generally utilized. Although designed for postpartum, the Edinburgh postnatal depression scale can also be utilized throughout pregnancy.^{14,25-28}

The same five depressive symptoms over a two-week period are still required for the diagnosis of depression. Postpartum depression is not a separate condition if a patient has a major depressive episode during the peripartum period. A substantial depressive episode arises during pregnancy or within four weeks of birth. The diagnosis should include either chronic depression or loss of interest in addition to the five symptoms (anhedonia). If any of the nine symptoms occur daily, it would suggest a divergence from the norm and aid diagnosis. Depressed mood (subjective or observed) and other symptoms like loss of interest or pleasure, insomnia or hypersomnia, psychomotor retardation or agitation, feelings of worthlessness or guilt, attempts and recurrent thoughts of suicide, suicidal ideation, loss of energy or feeling tired all the time, poor concentration, weight loss of 5%, etc., dominate the day. Depressive episodes are mild, moderate, or severe depending on symptom intensity and quantity.²⁹⁻³⁰

NONPHARMACOLOGIC TREATMENT OF ANTENATAL DEPRESSION

There hasn't been much systematic research on nonpharmacologic therapies for prenatal depression until lately. Grief, interpersonal conflicts, role transitions, and interpersonal deficits are the four main problem domains with respect to human psychosocial functioning that are addressed in interpersonal therapy (IPT), a brief, manual-driven psychotherapy. IPT is especially suited for the treatment of depressive pregnant women due to the significance of interpersonal connections in couples expecting a child as well as the considerable role shifts that occur during pregnancy and after birth. The role shifts and interpersonal conflicts that are typical of pregnancy and motherhood were the subject of Spinelli's adaptation of IPT for the treatment of pregnant women with prenatal depression. IPT considerably lessened the intensity of depressive symptoms and caused remission in all patients in a pilot study involving 13 women. Additionally, none of the women who were monitored after giving birth experienced postpartum depression. The small sample size and lack of a control group in this study are limitations, but the findings are promising. This method of treatment appears to lower the risk of depression after birth in

addition to treating the acute symptoms of depression during pregnancy. There are currently larger prospective trials of IPT during pregnancy.³¹

MANAGEMENT

There are numerous therapy alternatives that can also be utilized in combinations. Antidepressant medications and psychotherapy are effective treatments for mild to moderate symptoms. Women may view the use of medicine during pregnancy and after delivery as an issue because it could influence the infant through the placenta or breast milk. "Cognitive behavioral therapy (CBT)", psychodynamic therapy, interpersonal therapy, and counseling are some of the available psychotherapies. CBT is a more effective therapy than other psychological methods, according to a meta-analysis.¹⁴ CBT significantly reduced stress, anxiety, and depression symptoms, according to the study. Also, it was affordable.

When depression is mild to severe, antidepressants can be started either with or without CBT. The choice to employ antidepressant therapy should be made following a thorough risk-benefit analysis. The course of treatment should be individualized for each patient. "Tricyclic antidepressants (TCAs)" have been superseded as first-line medications by "Selective Serotonin Receptor Inhibitors (SSRIs)" and "Selective Nor-Epinephrine Reuptake Inhibitors (SNRIs)". Some medications enter the fetus through the placenta. However, the medicine's concentration varies and is influenced by maternal drug metabolism, serum concentration, and other factors. Congenital abnormalities pose a minimal danger in absolute terms. Poor APGAR ratings, preterm, and low birth weight have all been linked to SSRI use. A small percentage of newborns exhibit neuro-behavioural syndrome or neonatal abstinence syndrome.³²⁻³⁵

Antidepressant usage beyond twenty weeks of pregnancy is associated with an increased incidence of primary pulmonary hypertension. If SSRIs are ineffective for a patient, they may be switched to SNRIs, or a combination therapy may be tried and the symptoms monitored for improvement. The nerve cells in the brain can be stimulated using "Transcranial Magnetic Stimulation (TMS)," which is typically ineffective for treating severe depression. It is typically tried by individuals who are not responding to medication and is well tolerated.³²⁻³⁵ Trials with various drugs may not work for some people with severe depression. These are the female

patients for whom “*Electroconvulsive Therapy (ECT)*” may be used. Postpartum women may find ECT to be a simpler alternative, although additional medication trials for prenatal depression may be necessary. The sole medication for postpartum depression that has been licensed may be administered to women who decline ECT; nevertheless, it is not widely accessible.¹⁴

CONSEQUENCES OF PERINATAL DEPRESSION WITHOUT TREATMENT

Perinatal depression, if left untreated, can have terrible effects on the mother, her offspring, and her family. The mother-child relationship will suffer. They might have a strict and distant parenting style. Children don't form good childhood behaviors because they feel uneasy. Through maturity, this could continue, creating a vicious cycle. Postpartum depression affects a woman's ability to bond with her child, and this might last for a year. Poor bonding should be identified early on and treated. According to the literature, postnatal bonding failure would be brought on by antenatal bonding failure, therefore maternal connection before childbirth has to receive more focus. It was once believed that there was a one-way relationship between nursing and postpartum depression, with the latter leading to decreased rates of breastfeeding initiation and early cessation. Recent studies, however, indicate that while postpartum depression may lower breastfeeding rates, quitting nursing may raise your chance of developing postpartum depression. Additionally, there is some research that suggests nursing may help a mother recover from symptoms of postpartum depression more quickly.^{14,36,37}

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