

Postnatal Depression Question Answers

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As the nurse you are working with a postpartum woman who appears to be having some postpartum mental health issues, what would you include in your assessment, and what assessments or questions would you want to ask about the newborn? What would alert you that you should be concerned that the newborn may not be getting adequate care related to the mother's condition?

Approximately one in ten women suffer from [postnatal depression](#). As a nurse working with a postpartum woman with postnatal depression symptoms, it is very important to assess the mother's mental health on time. Evidence shows that postnatal depression impacts the ability of the mother to interact with responsiveness and sensitivity as a caregiver. It may affect the self-regulatory skills of an infant, making him/her more prone to psychopathology in the future. So, where it is essential to diagnose postnatal depression in a mother, it is essential to look for the signs of negligence from a mother in a newborn (Wittkowski et al., 2015). As a nurse, I will be concerned for the mother's health first. Only if she is taking care of herself properly will she be able to take care of her baby. So, my initial questions from her will be: how are her sleep patterns? How fresh or exhausted does she feel? How many meals does she take in a day, and has she felt any major weight loss after delivery? And then, I will question her relationship with the newborn, like how many times she holds her baby. How long does she hold her baby, and does she make any eye contact? Does her baby smile and respond to her? How many times does she feed her baby? Does it make her happy to spend time with the baby, or does she feel unhappy? Lastly, I will assess her mental health level one step further and will ask her if she has any suicidal or harmful thoughts for herself or her baby. If her response is below average for most of the questions, then I will be concerned that the newborn will not get adequate care from the mother.

If a patient were to be treated for postpartum

depression with psychotropic medications, would she still be able to breastfeed, and is this a safe practice? Discuss at least three medications that could potentially be used as a treatment option in both the lactating and nonlactating patient. As you discuss the medications, I want you to state what classification they are in, how they work at the cellular level, and what some of the adverse effects are.

Anxiety, mood swings, and insomnia have always been associated with postpartum depression. During the lactation period, the aim of the medication is to achieve a consistent balance between maternal psychiatric health and the safety of the lactating baby. Benzodiazepine and Z drugs are often the choice of interest for curing postpartum depression (Uguz F., 2019).

Many antidepressants are present in feeding mothers' milk. The drug concentration in the milk parallels the body fluid concentration of the drug, but due to the milk's affinity for the lipid environment, the drug concentration of the milk is higher than the body plasma. This concentration change can be used as a clinical parameter. Another parameter of clinical significance is the relative neonatal drug level (Uguz F., 2019).

Citalopram is a widely recommended antidepressant for PPD; it comes under the class Selective Serotonin Reuptake Inhibitor (SSRI). Citalopram initiates serotonergic activities in the CNS; also, lactating mothers experience delayed onset of lactogenesis II. How the infant maintains the drug's serum level is mainly determined by his/her genetic metabolic capacity. Behavioural side effects like fussiness and sleepiness are most evident as the side effects of citalopram if the mother takes the antidepressant during breastfeeding. Researchers have also evaluated that infants who have been exposed to the drug in utero during the last trimester experience poor neonatal adaption (Sharbaf Shoaib N, 2020).

Diazepam belongs to the class benzodiazepine and is frequently used to avert the withdrawal symptoms caused by postpartum depression. The drug acts as a sedative and facilitates the action of GABA neurotransmitters. It is often the preferred antidepressant because of its slow secretion in breast milk. The milk-to-plasma ratio and the infant's relative drug dosage are very low, being 0.2-0.58. No adverse reactions have been reported at this minimal level (Uguz F., 2019). The drug's chronic high dosages can lead to weight loss, feeding difficulty, and sedation of the infant.

Paroxetine is one of the most commonly prescribed SSIDs (Seminar Infectious Diseases) for curing postpartum depression. It depresses serotonin production by re-up-taking of serotonin via the serotonin receptor. The milk to plasma ratio is 0.39. Paroxetine is regarded as a safe SSID antidepressant as the dosage transferred to the neonate is 10% by weight of the dosage consumed by the mother; there are no adverse effects associated with this low concentration (Uguz F., 2016).

Compare postpartum “blues” and postpartum depression. You will need to discuss the differences in symptoms, onset, pathophysiology, and treatment. You must provide details in your discussion and use several sources to develop your response.

A postpartum psychological state is often divided into three classes depending upon the degree of severity. The first is the baby blues, the second is the postpartum depression, and the last is postpartum psychosis. Postpartum blues are generally less severe than psychic disorders; clinically, both can be differentiated based on timeline and symptoms.

Symptoms:

Baby blues:

The classical symptomatic signs of baby blues are anxiety, a sense of detachment, an urge to cry, and higher irritability. A few mothers also experience a lack of sleep and loss of appetite.

Postpartum depression:

The symptoms of baby blues and postpartum depression are identical at first, but with time, the postpartum depression symptoms grow intense. The signs and symptoms are depression, societal withdrawal, and insomnia. Intense irritability, fear of not becoming a good mother, fidgetiness, thoughts of harming the baby, and suicidal thoughts (Bass III, 2018).

Onset:

Baby blue manifests itself 1 to 3 days after the parturition time and lasts for just a week or two. Postpartum depression initially starts as baby blues, but the symptoms last longer, raging up to

months, depending upon the psychological condition and efficacy of the medication.

Treatment:

Baby blues are generally treated with counselling sessions; new mothers experiencing the baby blues are advised to get good sleep, talk to their spouse about their feelings, engage themselves in recreational activities, and spend time with the newborn.

However, for postpartum depression, along with the therapeutic sessions, antidepressants and psychotherapy are also advised. As the hormonal shift is the baseline cause of postpartum depression, hormonal therapy like estrogen replacement can help to cope with the depression (Shea, A. K., 2017).

Pathophysiology of Baby Blues and PPD:

Among all the new mothers, approx. 80% of women experience baby blues. The reason behind this is the immense physical, hormonal, and psychological changes associated with childbirth. Research has highlighted various factors as contributors to PPD; these include genetic, epigenetic, and biochemical circuit-level changes and neuroinflammation (Furtado, M., 2019). Consistent bouts of stress and a family history of depression serve as a predisposition for Postpartum depression. Epigenetic changes at HP1BP3 (Heterochromatin protein 1, binding protein 3) in the later stages result in the development of postpartum depression. The gene is concerned with estradiol regulation and, thus, is a key determinant of the mother's health.

References

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