



Risk factors and management of perinatal depression during the perinatal period

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ABOUT THE STUDY

Perinatal depression refers to significant and small depressive episodes that occur during pregnancy (antenatal depression) or within the first 12 months following delivery (postnatal depression). Antenatal depression is a substantial health issue, although it has received less attention than postpartum depression. More than 20% of pregnant women and mothers suffer from perinatal depression. In the United States, up to 10.5% of new mothers suffer from serious depression. Unipolar depression has a major contribution to the burden of disease, being at third place overall and ninth place in low-income nations, but at first position in middle- and high-income countries (Grunsfeld et al., 2006, Kile et al., 2006). Depression is the primary source of disease burden in both high- and low- and middle-income nations for women.

Identifying PND in health care settings has been advocated as an effective method of facilitating detection and treatment. The American Academy of Pediatrics, for example, recommends monitoring moms in paediatric settings at 1, 2, 4, and 6 months after delivery, when their kid is due for a well-child visit. However, there are major challenges to addressing PND in health care settings; physicians express concerns about being too busy to screen, lacking confidence in addressing maternal depression, and being unaware of accessible mental health resources to send caregivers to.

Depression and anxiety during pregnancy are two of the most significant risk factors for postpartum depression. Postpartum depression, on the other hand, is connected with considerable mental and relational suffering, as well as impaired physical and social functioning (Marin et al., 2005). Although a number of large-scale, high-quality studies have assessed the prevalence of pre and postnatal depression (i.e., an episode of major depression) using gold standard assessment methods

(i.e., diagnostic interviewing), these estimates are, to the best of our knowledge, based solely on episodic criteria or symptom severity; they do not include the full diagnostic criteria for major depressive disorder. As a result, bipolar disorders are likely to contribute to the occurrence of postpartum depression.

Untreated postpartum depression has negative consequences for both the mother and her baby. It can cause great depression, anxiety, and a lack of interest in life and the child in the mother, resulting in poor or absent maternal bonding with the infant. It is also linked to failure to commence breastfeeding or nursing for a shorter period of time. When prenatal depression is severe, the mother's symptoms can lead to suicidal or infanticide thoughts, or even self-harm or infanticide (Starkstein et al., 2008). Suicide is the second largest cause of death for women in the first year after birth, accounting for 20% of all deaths.

By screening pregnant and postpartum patients for mood and anxiety disorders, primary care practitioners can drastically increase the rate of detection and diagnosis. Screening improves outcomes in depressive mothers, according to trials conducted in the United States. As a result, a number of organizations urge screening for all women during the perinatal period. The Edinburgh Postnatal Depression Scale (EPDS) is one of the most basic and reliable screening instruments. The EPDS is a cross-culturally validated 10-question form that a woman can complete in a waiting room, online, or with a clinician in 2 to 3 minutes. Sensitivity and specificity range from 60% to 78%, and studies have shown that the EPDS is twice as effective in detecting depression as a clinician's interview.

Although screening is helpful for detecting prenatal depression, screening alone will not improve outcomes unless mechanisms are in place to respond to a positive screen and therapy and follow-up occur. Individual

psychotherapy and other modalities, such as postpartum support groups, family therapy, remote video conferencing, phone check-ins, and home visits with qualified mental health specialists, are frequently beneficial in treating these illnesses without the use of medication (Vijayaraghavan et al., 2002). Primary care and internal medicine hospital departments and outpatient practices have had success treating these patients using an integrated care model developed in collaboration between the Health Resources and Services Administration and the Substance Abuse and Mental Health Services Administration.

Despite advances in non-pharmacologic techniques for treating prenatal depression, medication is occasionally required. In present practice, many women are generally encouraged to cease taking all psychiatric drugs when they become pregnant or breastfeed, but research has revealed that a more nuanced and customized approach is necessary. Many mental drugs have been demonstrated to be safe during pregnancy and lactation. Given the facts on the effects of untreated depression on pregnancy and child development, many reproductive psychiatrists have discovered that, for some women,

taking medication is more beneficial to the mother's health and the kid's development than not taking it.

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