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Mini Review

Postpartum depression: An overview

Abstract

Bringing a child into the world causes a lot of upheaval and it is normal, after childbirth, to feel sometimes happy, sometimes sad and irritable. Soon after the birth of their child, the majority of women (about 80%) experience what is called the 3rd day syndrome, or "baby blues". Postpartum depression is a much more serious disorder that occurs around the third week after delivery. Symptoms occur for weeks to months or more. Postpartum depression can occur in the first 12 months after delivery, but in the majority of cases it occurs in the first few weeks after birth. It is manifested by anxiety, insomnia and depressive symptoms. The treatment of postpartum depression is essentially psychotherapeutic although SSRIs are used. A new molecule, brexanolone, may change the prognosis.

Introduction

Postpartum depressions are common, affecting at least 10% of mothers [1,2]. They are serious because of their impact on mother-baby relationships and on the child's development [3]. However, these depressions seem very insufficiently diagnosed and treated: some studies have found that about half of these depressions are not recognized by the general practitioner or other health professionals working with the mother and that, among diagnosed mothers, almost a third do not follow the proposed treatment. These findings highlight the importance of identifying at-risk mothers and prevention of postpartum depression, and the need for effective and well-accepted screening and treatment for installed depression.

Clinical features

The onset is often insidious, after a normothymic phase or prolonged "baby-blues"; it can also prolong ante-natal depression. Table sometimes misleading, the postpartum depression is manifested by a classic picture of depressive syndrome. Postnatal depression has the distinction of starting before the fourth week after delivery, according to the Diagnostic and Statistical Manual of Mental Disorders [DSM-V]; however, the scientific literature discusses this diagnosis up to 1 year after delivery [4]. The cognitions are negative, with in particular sadness, a self-deprecation. The patient can be slowed, asthenic, and her instinctual functions - sleep, diet, libido - are sometimes disturbed. Depression is marked by a sad mood, irritability, anxiety sometimes expressed in the form of impulse phobias. The feeling of incapacity and the self-accusations concern the maternal

function and especially the care of the child. These disorders are minimized or even hidden from the entourage by the woman for fear of being judged. They sometimes express themselves indirectly through somatic complaints, excessive fears about the health of the child leading to repeated pediatric consultations. They can still manifest themselves through early functional disorders of the infant (sleep, feeding ...) or even colic, frequent crying. They can finally be revealed by disorders of mother-baby interactions. Indeed, this malaise is felt on the mother-baby relationship. The interactions are disturbed both quantitatively and qualitatively. The care is rigid, not adapted to the obvious needs of the baby; they are operative, performed without pleasure. Moments of excessive anxious solicitude can alternate with total unavailability of the baby, or even intolerance to crying. There is a risk of maltreatment through gross negligence or abuse by the mother. Different types of disorders should warn about a possible psychic suffering of the baby: behavioral disorders (agitation or apathy), psychomotor development disorders, relationship disorders or somatic disorders.

Ideas of death may also appear, and more rarely are associated with suicide attempts [5]. It has some clinical peculiarities such as evening worsening, emotional lability, and marked difficulties of falling asleep, loss of esteem mothering and anxiety centered on the baby. Postpartum depression is usually of moderate intensity. Anxiety is in the foreground and precedes depressive signs. Somatic symptoms are the most common reasons for consultation. It is then a privileged moment for the screening and evocation of a malaise. The guilt of not feeling the expected maternal happiness is central. Impulse phobias may appear: fear of hurting the child, throwing him, etc. [6]. This is a common symptom that does

not indicate either the danger or the severity of the pathology, and the patient to whom it will be explained will be reassured. The symptomatology of the depressive episode is sometimes associated with a delusional melancholic production whose theme is centered on the baby (idea of substitution, poisoning, bewitchment) or on filiation (negation of the couple, of maternity, child of God ...). The anxieties of death are massive and concern the child, the mother herself. The risk of suicide and / or infanticide is major.

Simple means can be used to screen at-risk mothers in the period before or after delivery [7]. It was shown that the Edinburgh Post-natal Depression Scale [8], initially designed for the screening of postpartum depression, allowed, by measuring the intensity of post-partum blues depressive symptomatology, to identify mothers at high risk of later developing postpartum depression. The main preventive psychological interventions that have been evaluated are supportive and educational group therapies [9,10] but these studies are limited by the limited number of subjects or the absence of a control group.

Etiopathology of postpartum depression

Although the pathogenesis of postpartum depression is still unclear, the authors agree that there is no single cause. Some factors predispose to a psychic disorder of pregnancy and postpartum. These are contributing factors and situations of vulnerability that are not direct causal factors. Physical, hormonal, social, psychological and emotional factors can all play a role in triggering the disease. This is called the "biopsychosocial model of depression," which is accepted by most researchers and clinicians. The factors (s) that trigger postpartum depression vary from person to person. From another angle, the occurrence of a postpartum depression is considered: The decompensation of anterior pathology (bipolar disorder, anxiety disorder ...) [11]. It is suggested as well that immune mechanisms may play a role in the etiopathology of postpartum depressive mood shifts [12].

Treatment

Universal screening for postpartum depression is recommended so the Postpartum Depression Scale in Edinburgh is widely used [13]. The management of postpartum depression is coordinated by the psychiatrist and involves the active participation of gynecologists, psychologists and treating physicians. The indications depend on the severity of the chart: psychotherapy, antidepressant treatment or a combination of two. Psychotherapies are the main treatment for postpartum depression [14]. Indeed, the effectiveness of antidepressants is not demonstrated in postpartum depression [15], their safety is doubtful in the case of breastfeeding because they pass into the breast milk and the baby's serum and their effects on a developing brain are not known. On the other hand, mothers very often refuse their prescription. However, it should be noted that the general methodological limitations, more or less important according to the studies, compromise the validity and / or the generalizability of the results: thus, a Cochrane conclude their precise and complete review of the

open or controlled studies of postpartum depression by writing that "the methodological limitations of these studies imply that the efficacy of these therapeutic approaches has not been clearly demonstrated and that there are very few proven facts about which should be based on recommendations of practice of care and health policy [16]. In the case of a severe picture, risk of suicide and / or infanticide, hospitalization is indicated, at best in a mother-baby unit. It contains the symptoms of the mother, supports the maternal function and accompanies the establishment of the mother-baby bond. Nevertheless, in some cases, the mother will have to be separated from her baby: in case of serious maternal failure, in case of increased symptoms in the presence of the baby or in case of immediate danger for the latter. Contacts with the baby are reinstated as soon as possible and with the mediation of the caregivers. The work of psychotherapy is spread along two axes: individual psychotherapy for the mother and therapeutic consultations mother-baby [17].

A drug specifically designed to treat postpartum depression is about to receive approval from the United States Health Authority (FDA): brexanolone. Immediately after birth, hormone levels decrease, as well as that of a neurosteroid supposedly activated receptors. In women with postnatal depression, these receptors are not activated, or take longer. The brexanolone is used to reactivate, unlike antidepressants that increase levels of serotonin, a hormone that plays on mood. Submitted to the FDA in April, after successfully completing the clinical trials, the brexanolone was awarded the status of "revolutionary treatment", to speed up the approval process, which should be completed by December 19th 2018. It only remains to see if it works with all women suffering from postpartum depression [18].

Conclusion

Postpartum depression is a very common clinical entity. It can be considered as a public health problem, not only because of its frequency but also because of its harmful consequences on the newborn, on the conjugal relationship, or even on the family balance. Especially, since it can announce the beginning of a chronic pathology of the mood in the mother. Hence the need for its prevention by action on risk factors, its screening, and its multidisciplinary therapeutic management.

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