Review of Contemporary Philosophy
ISSN: 1841-5261, e-ISSN: 2471-089X
Vol 22 (1), 2023
Pp 2630 - 2639

Nurses' Role in Postpartum Depression Care- An Updated Review

[1]-Manal Nayaf Almutairi,[2]-Wedad Naser Aleneze,[3]-Faten Aden Almutairi,[4]-Mariam Saud Alanazi,[5]-Nouf Saleh Almutairi,[6]-Qanaa Ahmed Zaid Abdullah,[7]-Sultan Mufareh Ahmed Asiri,[8]-Itizaz Judaya Alruwaili,[9]-Zaki Yahya Boker Hawbani,[10]-Mawada Mohammed Alshammari,[11]-Yasemeen Jumyya Almutairi,[12]-Taghreed Bakr Shatarah,[13]-Noha Ibrahim Yahya,[14]-Mohamad Bader Almotiry,[15]- mal Mashabb Albogami

1. Ksa, Ministry Of Health
2. Ksa, Ministry Of Health
3. Ksa, Ministry Of Health, Khalidiya Primary Health Care Center
4. Ksa, Ministry Of Health, Al Yamamah Health Center
5. Ksa, Ministry Of Health, Alkaldiya Primary Health Care Alqassim Cluster
6. Ksa, Ministry Of Health, Sabya General Hospital.
7. Ksa, Ministry Of Health, Irada Mental Health Hospital In Jazan
8. Ksa, Ministry Of Health, Western Tareef Primary Healthcare Center
9. Ksa, Ministry Of Health, Irada Mental Health Hospital In Jazan
10. Ksa, Ministry Of Health, Imam Abdulrahman Alfaisal Hospital
11. Ksa, Ministry Of Health, Alajaweed Health Center
12. Ksa, Ministry Of Health
13. Ksa, Ministry Of Health, Jazan Health Clustar
14. Ksa, Ministry Of Health, Diriyah Hospital
15. Ksa, Ministry Of Health, Laban Alsharqi Health Center

Abstract:

Background: Postpartum depression (PPD) is a major mood disorder that affects individuals within one year of childbirth. It is a significant public health concern as it can severely impair the mother's ability to care for herself and her infant, potentially leading to long-term developmental issues for the child. PPD symptoms include persistent sadness, anxiety, and sleep disturbances, often resulting in impaired bonding with the infant. Early detection and treatment are crucial to preventing adverse outcomes. Nurses play a critical role in screening, supporting, and managing care for individuals with PPD.

Aim: This review aims to explore the role of nurses in the care and management of PPD, emphasizing early identification, screening, and intervention strategies. It also examines the importance of nursing education and the integration of mental health care into routine postpartum care.

Methods: An updated literature review was conducted to gather relevant studies and evidence on nurses' roles in managing PPD. Key areas explored include screening tools, therapeutic interventions, and the impact of nursing support on patient outcomes. Articles from clinical practice guidelines, systematic reviews, and primary research were analyzed to provide a comprehensive understanding of the current evidence.

Results: Nurses are essential in identifying PPD symptoms through routine screenings such as the Edinburgh Postnatal Depression Scale (EPDS). Their role extends beyond screening to providing emotional support, education, and referrals to mental health professionals. Nurses' interventions, including psychoeducation, counseling, and the promotion of social support, significantly improve maternal mental health outcomes. Additionally, integrating mental health care into routine postpartum care is crucial for effective PPD management.

Conclusion: Nurses have a vital role in the early identification, support, and management of PPD. Incorporating mental health care into routine postpartum visits and providing comprehensive nursing care can improve maternal and child well-being. Continued education and training for nurses are essential to enhance their role in addressing PPD.
Keywords: Postpartum depression, nurses' role, screening, intervention, Edinburgh Postnatal Depression Scale, mental health, postpartum care.
Received: 07 october 2023 **Revised:** 22 November 2023 **Accepted:** 06 December 2023

Introduction:

Postpartum depression (PPD) is a mood disorder that affects individuals within one year following childbirth. The Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5) has now integrated postpartum depression under the broader term "perinatal depression" [1]. Peripartum depression refers to a major depressive episode that begins during pregnancy or within four weeks postpartum, encompassing both prenatal and postpartum depression. PPD is not categorized as a distinct disorder in the DSM-5; rather, it is subsumed under peripartum depression [2]. In contrast to the "baby blues," which generally resolve within a few weeks, PPD is more severe and can persist for months if left untreated. The symptoms of depression in PPD include persistent sadness, diminished interest in usual activities, low self-esteem, sleep disturbances, loss of appetite, anxiety, irritability, hostility towards the infant, self-blame, and feelings of humiliation. Individuals with PPD may also experience changes in their eating and sleeping patterns, difficulty bonding with their child, and pervasive feelings of hopelessness or worthlessness [3]. It is essential to recognize and address PPD promptly to safeguard the health and well-being of both the mother and her child. If untreated, PPD can impede a mother's ability to care for her baby, potentially leading to long-term developmental issues in the child, such as emotional and behavioral problems. Additionally, untreated PPD can strain familial relationships and elevate the risk of suicidal thoughts or actions [4]. Screening for PPD should be integrated into routine postpartum care, utilizing tools such as the Edinburgh Postnatal Depression Scale (EPDS) to identify individuals at risk. Treatment generally involves a combination of psychotherapy, support groups, and pharmacological interventions, including antidepressants, which are considered safe for use during lactation. Up to 50% of PPD cases go undiagnosed due to patients' reluctance to disclose their symptoms, often because of the stigma surrounding PPD, including fears of abandonment and insufficient support after disclosure [5]. Promoting awareness of PPD, reducing stigma, and ensuring access to mental health resources are critical steps in supporting new parents and fostering healthy family dynamics.

Etiology

The precise cause of PPD remains incompletely understood; however, several potential etiological factors, such as hormonal fluctuations, genetic predisposition, and psychosocial stressors, are thought to contribute to its onset. The rapid decline in estrogen and progesterone levels post-delivery, combined with the stress and sleep deprivation associated with newborn care, may trigger depressive episodes in individuals who are predisposed to depression. A meta-analysis of 33 studies highlighted several risk factors for PPD, including gestational diabetes, having a male infant, a history of depression, and the use of epidural anesthesia. However, further investigation is required to determine the actual significance of some of these factors, particularly the infant's sex and epidural anesthesia use [3]. Beyond hormonal changes, alterations in various metabolic pathways, such as energy metabolism, purine and amino acid cycles, steroid and neurotransmitter metabolism, and exposure to xenobiotics, may also be implicated in the development of postpartum depression [6].

Postpartum Depression Risk Factors

Several factors are associated with an increased risk of developing postpartum depression:

- **Psychological Factors**: A personal history of depression and anxiety, premenstrual syndrome, negative attitudes towards the baby, dissatisfaction with the baby's sex, and a history of sexual abuse.
- **Obstetric Risk Factors**: High-risk pregnancies, hospitalization during pregnancy, and traumatic childbirth experiences, including emergency Cesarean sections, in-utero meconium passage, umbilical cord prolapse, preterm or low-birth-weight infants, and low hemoglobin levels.

- **Social Factors**: A lack of social support, exposure to domestic violence (including sexual, physical, or verbal abuse), smoking, and young maternal age during pregnancy [6].
- **Lifestyle Factors**: Poor dietary habits, insufficient physical activity, vitamin B6 deficiency (which affects serotonin production), and inadequate sleep. Exercise has been shown to reduce the negative self-esteem associated with depression, boost endogenous endorphins and opioids, and enhance mental health, self-confidence, and problem-solving abilities [7].
- **Family History of Psychiatric Disorders**: Recent studies have indicated that a family history of psychiatric disorders increases the likelihood of developing postpartum depression. This heightened risk is believed to stem from both genetic and environmental factors, particularly those related to a lack of social support, which is a known risk factor for PPD [8].

Epidemiology

Depression is the most prevalent psychiatric disorder during the peripartum period, and postpartum depression (PPD) significantly contributes to an elevated risk of parental suicide, which ranks as the second most common cause of mortality in the postpartum period [9]. Globally, PPD affects between 6.5% and 20% of individuals following childbirth, with its prevalence influenced by various factors such as cultural and economic conditions of a country [10]. Studies have revealed inconsistent risk factors for PPD, contributing to a lack of uniformity across findings [3]. Research indicates that PPD is more commonly observed in adolescents, individuals delivering preterm infants, and those residing in urban areas. In a meta-analysis, the highest prevalence of PPD was observed in China at 21.4%, followed by Japan at 14%, and the United States at 8.6%. The onset of PPD typically occurs around 14 weeks postpartum [3]. Additionally, Black and Hispanic patients often report the emergence of symptoms within two weeks of delivery, while White patients tend to experience the onset of symptoms later.

Pathophysiology

The pathogenesis of PPD remains incompletely understood but is considered to be multifactorial. Genetic, hormonal, psychological, and psychosocial stressors are hypothesized to contribute to its development [10][11][12][13]. The involvement of reproductive hormones in depressive behavior suggests that neuroendocrine dysfunction plays a role in PPD. Substantial evidence supports the hypothesis that fluctuations in reproductive hormones, particularly following childbirth, can trigger depressive episodes in individuals who are predisposed. The pathophysiology of PPD is believed to involve disruptions in various biological and endocrine systems, such as the immune system, hypothalamic-pituitary-adrenal (HPA) axis, and lactogenic hormones.

The HPA axis plays a critical role in the disease process of postpartum depression. In response to stress and trauma, the HPA axis releases cortisol; however, HPA dysfunction can result in inadequate catecholamine release, leading to an impaired stress response. During pregnancy, HPA-releasing hormones are elevated and remain so up to 12 weeks postpartum. Recent findings suggest a potential link between PPD and dysregulated gamma-aminobutyric acid (GABA) neurotransmission, with imbalances in this inhibitory neurotransmitter possibly contributing to depressive symptoms [10]. A rapid decline in reproductive hormones such as estradiol and progesterone following childbirth can act as a stressor in vulnerable individuals, precipitating depressive symptoms. Elevated cortisol levels and decreased tryptophan levels have been observed in affected individuals [6]. Oxytocin and prolactin also play pivotal roles in the pathophysiology of PPD. These hormones are involved in regulating the milk let-down reflex and breast milk synthesis, with an impaired ability to lactate frequently correlating with the onset of PPD. Notably, reduced oxytocin levels are associated with PPD and early weaning, and lower oxytocin levels during the third trimester have been linked to increased depressive symptoms both during pregnancy and postpartum [14].

History and Physical

PPD is diagnosed when a patient exhibits at least five depressive symptoms for a duration of at least two weeks, with symptom onset typically occurring up to 12 months postpartum [15]. The diagnostic criteria include depressive mood (either subjective or observed), loss of interest or pleasure (anhedonia), sleep disturbances (insomnia or hypersomnia), psychomotor retardation or agitation, feelings of worthlessness or guilt, fatigue or loss of energy, suicidal ideation or attempts, recurrent thoughts of death, difficulty

concentrating or indecisiveness, and significant changes in weight or appetite (e.g., a weight change of 5% over one month). These symptoms must occur nearly every day and represent a deviation from the individual's prior functioning. For a diagnosis of PPD, either depression or anhedonia must be present.

The symptoms of PPD can result in substantial distress and functional impairment. These symptoms must not be attributable to substance use or a medical condition, nor should they be a manifestation of a psychotic disorder or prior manic or hypomanic episodes [9]. According to the International Classification of Diseases-10, depressive episodes are characterized by a persistent low mood, diminished energy, and a reduction in interest and enjoyment. Other symptoms include reduced capacity for concentration, early morning awakening, psychomotor retardation, significant weight loss, loss of libido, and decreased appetite, all of which may not improve with changes in circumstances. The severity of the depressive episode may be classified as mild, moderate, or severe based on the number and intensity of symptoms. The signs and symptoms of PPD mirror those of non-puerperal depression, with the added factor of a recent childbirth. Symptoms commonly include depressed mood, loss of interest, changes in sleep and appetite, feelings of worthlessness, difficulties with concentration, and suicidal ideation. Anxiety may also be present. Some patients with PPD may exhibit psychotic symptoms, such as delusions or hallucinations, with extreme cases manifesting as voices instructing harm toward the infant. PPD can have significant adverse consequences, including impaired maternal-infant bonding, breastfeeding difficulties, detrimental parenting behaviors, marital conflict, and negative impacts on the child's physical and psychological development. Remission of PPD symptoms is associated with a lower risk of behavioral and psychiatric issues in the offspring. A prior episode of PPD increases the likelihood of subsequent major depressive episodes, bipolar disorder, and future occurrences of PPD. The history of PPD and postpartum psychosis in the patient or their family should be carefully considered during diagnosis.

Evaluation

The American College of Obstetricians and Gynecologists (ACOG), the American Academy of Pediatrics (AAP), and the American Academy of Family Medicine (AAFP) advocate for universal screening of all postpartum patients for depression using the Edinburgh Postnatal Depression Scale (EPDS) [3]. A comprehensive evaluation should include an assessment of the patient's substance use history, including drug and alcohol consumption, smoking habits, as well as any prescription or over-the-counter medications. Screening for postpartum depression (PPD) should be conducted during both pregnancy and the postpartum period [16]. Multiple screening instruments are available, with the EPDS being the most widely used. This 10-item questionnaire, which can be completed by patients in just a few minutes, has been shown that a score of ≥13 correlates with an increased risk of PPD, prompting further clinical evaluation. The primary objectives of the clinical assessment are to establish the diagnosis, evaluate risks of suicidality or homicidality, and exclude other psychiatric disorders [17].

Treatment / Management

Preventive interventions such as counseling, cognitive behavioral therapy (CBT), and interpersonal therapy have proven effective in reducing the risk of postpartum depression in high-risk patients. Clinicians are encouraged to identify and implement these preventative strategies for individuals at heightened risk of developing PPD [15].

Antidepressant Medications

The primary treatment for peripartum depression is psychotherapy in conjunction with antidepressant medications. Psychotherapy is recommended as the first-line approach for patients with mild to moderate peripartum depression, while a combination of psychotherapy and pharmacotherapy is advised for individuals with moderate to severe depression. Referral to specialized behavioral health resources may also be warranted [15]. According to ACOG guidelines, selective serotonin reuptake inhibitors (SSRIs), serotonin-norepinephrine reuptake inhibitors (SNRIs), and tricyclic antidepressants (TCAs) are the recommended pharmacological therapies for PPD [9].

SSRIs are considered the first-line pharmacological treatment for PPD. If SSRIs prove ineffective, switching to SNRIs or mirtazapine may be considered. Sertraline and escitalopram are commonly recommended as initial choices due to their extensive safety profiles. While fluoxetine and paroxetine may be considered if they have been previously effective for a patient, these drugs carry an increased risk of neonatal adaptation

syndrome. In cases where patients have previously benefited from a particular antidepressant, continuation of that medication during or after pregnancy is generally appropriate [15]. The ultimate goal of PPD treatment is the remission or resolution of depressive symptoms, with symptom improvement measured using the same screening tool employed for initial assessment. A 50% or greater reduction in symptoms typically signifies a treatment response. Algorithms may assist in adjusting medication dosages, and ongoing symptom monitoring through tools like the Patient Health Questionnaire-9 or EPDS is essential. Unaddressed mental health conditions during the perinatal period carry risks, as do pharmacological treatments, and both should be managed with awareness. The lowest effective dose of medication should be administered to achieve symptom remission, but it is crucial to avoid under-treatment, a common issue in obstetrics. Polypharmacy and switching medications unnecessarily should be avoided when a single medication can effectively manage symptoms [15]. While some benefits may be observed within the first week of starting oral therapy, full symptom improvement generally takes between 4 to 8 weeks [9].

Once an effective medication regimen is established, continuation of treatment for at least 6 to 12 months is recommended to prevent symptom recurrence [18]. Discontinuing medical therapy during pregnancy or in the postpartum period poses a significant risk of relapse and is not advised. Furthermore, discontinuation of medication during the third trimester, in an attempt to mitigate neonatal adaptation syndrome, is also discouraged. Abrupt cessation of SSRIs or SNRIs can lead to complications unless a gradual tapering schedule over 2 to 4 weeks is followed. Withdrawal symptoms may include gastrointestinal upset, agitation, anxiety, headaches, dizziness, fatigue, sleep disturbances, tremors, muscle aches, and electric shock-like sensations [15]. For lactating individuals, pharmacologic recommendations should address the potential risks and benefits of antidepressant use while breastfeeding, as well as the risks of untreated depression. Repetitive transcranial magnetic stimulation (rTMS) may serve as an alternative treatment option for breastfeeding mothers concerned about exposing their infants to medication. The risk associated with breastfeeding while using SSRIs is considered low, and patients can generally continue breastfeeding while on antidepressants. Cognitive behavioral therapy, either alone or in combination with sertraline, has demonstrated efficacy in managing PPD after 12 weeks, with cognitive behavioral therapy yielding the most rapid initial improvements following treatment initiation.

Neurosteroid Therapy

Brexanolone, an intravenous neurosteroid that exerts a positive effect on GABA-A receptors, was approved by the Food and Drug Administration (FDA) in March 2019 specifically for the treatment of postpartum depression (PPD). This medication may be considered for individuals with moderate to severe depression during the third trimester or the postpartum period. Patients undergoing brexanolone treatment must be enrolled in the Risk Evaluation and Mitigation Strategy Program [19]. While brexanolone has a rapid onset of action, it is not widely accessible and may be cost-prohibitive. There is a lack of data supporting its safety during breastfeeding or its efficacy beyond 30 days of use. Inpatient monitoring is essential to observe for potential sedative effects, sudden loss of consciousness, and hypoxia during the infusion process [9][15].

Brexanolone, an analog of allopregnanolone—a progesterone metabolite—was the first drug approved by the FDA for the treatment of moderate to severe PPD [19]. It is administered intravenously as a continuous infusion over 60 hours, typically lasting around 2.5 days. Clinical trials have demonstrated that brexanolone is generally well tolerated by women with moderate to severe PPD and can provide a rapid therapeutic response [20][21]. Breastfeeding is not recommended during the treatment and for four days following the infusion. Additional clinical trials are necessary to evaluate the long-term safety and efficacy of brexanolone in the treatment of PPD [15]. Zuranolone, a neuroactive steroid similar to brexanolone, also modulates GABA-A receptors and was FDA-approved on August 4, 2023, for the management of PPD. It is administered as a 50 mg oral dose taken every night with a fat-containing meal (700 calories; 30% fat) for 14 days. Zuranolone can be used alone or in combination with oral antidepressants. Its onset of action is rapid, occurring within hours to days, providing prompt relief. However, due to the central nervous system depression associated with zuranolone, patients should be advised that their ability to drive may be impaired. Additionally, zuranolone has been linked to potential harm to the fetus during pregnancy and lactation. Overall, zuranolone is well tolerated with minimal side effects, with the most commonly reported

adverse event being somnolence, experienced by over 26% of patients [22]. As safety and efficacy beyond 14 days of use have not been established, it is not recommended for use beyond this duration [10].

Nonpharmacologic Therapies

Transcranial magnetic stimulation (TMS) is a noninvasive therapeutic procedure that utilizes magnetic waves to stimulate and activate specific nerve cells in the brain. These cells are often underactive in individuals suffering from major depression [23]. TMS is typically administered once daily for 4 to 6 weeks to achieve its therapeutic effect. This treatment is considered for patients who do not respond to antidepressants and psychotherapy. Generally, TMS is safe and well tolerated; however, some patients may experience mild side effects such as headaches, lightheadedness, scalp discomfort, and facial muscle twitching. Rare but serious side effects include seizures, hearing loss if ear protection is insufficient, and mania in individuals with bipolar disorder [24]. While initial findings are promising, further research is required to assess the full benefits of TMS for PPD [23]. For patients with severe PPD who do not respond to psychotherapy or pharmacotherapy, electroconvulsive therapy (ECT) may be indicated, particularly in cases where patients have not responded to four consecutive medication trials. ECT is particularly beneficial for individuals with psychotic depression, those with suicidal or infanticidal ideation, and those experiencing severe malnutrition and dehydration due to refusal to eat [25][26]. Several observational studies suggest that ECT may be a safer treatment option for lactating individuals, as it generally results in fewer adverse events for both the mother and infant [27][28]. However, some experts express reservations regarding the use of ECT for PPD.

Differential Diagnosis

When assessing postpartum depression (PPD), it is essential to consider several differential diagnoses. One such condition is baby blues, which typically occurs within a week following childbirth and resolves spontaneously within 10 to 14 days postpartum. This transient condition affects approximately 50% to 75% of patients and does not require treatment. Symptoms may include episodes of crying, sadness, anxiety, irritability, sleep disturbances, appetite changes, confusion, and fatigue. Despite these symptoms, the baby blues do not impair daily functioning or the ability to care for the infant. However, severe cases of baby blues are associated with an increased risk of developing PPD [29]. Hyperthyroidism and hypothyroidism can also contribute to mood disorders, and thyroid function should be assessed through thyroid-stimulating hormone testing to rule out these conditions. Postpartum anxiety, adjustment disorder, or posttraumatic stress disorder (PTSD) are other considerations. Postpartum anxiety is characterized by excessive worry, while adjustment disorder involves emotional and behavioral responses to the stresses of childbirth that are typically less severe and transient compared to PPD. PTSD, on the other hand, arises from trauma-related symptoms resulting from a difficult or traumatic birth experience. Postpartum psychosis is another critical differential diagnosis, occurring in the first 4 weeks after delivery. It typically manifests within 3 to 10 days postpartum, though it may develop up to 4 weeks after childbirth. This disorder is a psychiatric emergency and carries a significant risk of suicide and infanticide. Symptoms include hallucinations, agitation, erratic behavior, disorganized thoughts, and delusions. Postpartum psychosis is relatively rare, affecting approximately 1 to 2 women per 1000 pregnancies, and is associated with an acute onset of either manic or depressive psychosis [15].

Prognosis

The prognosis of postpartum depression (PPD) is heavily influenced by the timeliness of treatment. Delayed intervention is a critical factor in the duration of the condition, with approximately 25% of individuals experiencing symptoms for up to 3 years after childbirth [15]. The effects of PPD extend beyond potential physical harm to the infant, impacting parent-infant bonding. Children born to mothers with PPD may face developmental challenges, including behavioral issues, cognitive delays, and an increased risk of early-onset depressive disorders. Furthermore, these children are at a heightened risk for obesity and may experience difficulties in social interactions. The course of PPD can be prolonged without appropriate management, as it may contribute to chronic depressive disorders if untreated. Additionally, untreated PPD increases the likelihood of future episodes of major depression. For the entire family, PPD serves as a source of stress, with potential ramifications for the children, who may experience language development delays,

sleeping and eating difficulties, excessive crying, and attention-deficit/hyperactivity disorder. Medication adjustments may be necessary based on clinical assessment and validated screening tools, particularly as pregnancy advances and physiological changes occur, such as increased renal clearance and altered enzyme activity. In some cases, an increase in medication dosage may be required. Empiric down-titration of psychiatric medications during the third trimester is not advised, as it has not been shown to improve neonatal outcomes and may worsen mental health conditions [15].

Complications

Postpartum depression (PPD) can lead to long-term consequences if left untreated, affecting both the parents and the infant. In addition to the potential for chronic depressive disorders, PPD may predispose individuals to recurrent episodes of major depression. Even when treated, PPD can pose a risk for future depressive episodes. Furthermore, PPD significantly impacts the entire family, particularly the children. Children with untreated depression are more likely to develop emotional and behavioral issues, including language development delays, sleep disturbances, eating difficulties, excessive crying, and attention-deficit/hyperactivity disorder. When untreated, PPD can result in disrupted health behaviors, strained relationships, and alterations in both physiological and psychological well-being. The condition may pose a risk not only to the mother but also to the fetus, the partner, and the family unit as a whole. Consequently, the American College of Obstetricians and Gynecologists (ACOG) does not recommend discontinuing or withholding psychiatric medications solely due to pregnancy status [15].

Nursing Interventions Plan in Postpartum Depression:

Postpartum depression (PPD) is a significant mental health condition affecting many women following childbirth. Effective nursing interventions are essential in the management of PPD, as nurses play a critical role in early identification, support, and ongoing care. A comprehensive nursing intervention plan for postpartum depression should focus on assessment, education, emotional support, and collaboration with other healthcare professionals to ensure the best outcomes for both the mother and the infant.

Assessment and Screening

The first step in the nursing intervention plan is thorough assessment and screening for PPD. Nurses must regularly assess new mothers for signs and symptoms of depression during routine postpartum visits and hospital stays. Screening tools such as the Edinburgh Postnatal Depression Scale (EPDS) or the Patient Health Questionnaire (PHQ-9) are commonly used to identify symptoms of depression. These assessments should be conducted not only in the hospital setting but also during follow-up visits to ensure that any emerging symptoms are detected early. Early identification is crucial, as untreated PPD can lead to long-term emotional and developmental consequences for both the mother and the infant. In addition to formal screenings, nurses should assess the mother's mood, sleep patterns, appetite, and ability to care for her baby. A thorough evaluation of the mother's social support network, family history of mental health disorders, and any previous episodes of depression is also essential in determining her risk for PPD. The nurse must remain observant of signs of severe depression, including suicidal thoughts or thoughts of harming the baby, as these indicate a need for immediate medical attention.

Emotional Support and Counseling

Emotional support is a cornerstone of nursing interventions for PPD. Nurses should provide empathetic listening and create a non-judgmental environment where the mother feels safe to express her feelings and concerns. Offering reassurance that PPD is a medical condition, not a reflection of personal failure, can help to reduce feelings of guilt and isolation. Nurses should provide mothers with information about the nature of PPD, emphasizing that it is treatable and that they are not alone in their experience. Cognitive-behavioral techniques, such as reframing negative thoughts and promoting positive thinking, can be integrated into nursing care to support the emotional well-being of mothers. Nurses can also offer relaxation techniques, such as deep breathing or mindfulness exercises, to help alleviate feelings of anxiety and stress. Encouraging mothers to engage in self-care activities, such as taking time for themselves and maintaining healthy sleep patterns, is vital for managing PPD symptoms.

Education and Resources

Education is an essential aspect of nursing care for women with PPD. Nurses should provide information about the symptoms, causes, and treatment options for PPD, including both pharmacologic and non-

pharmacologic interventions. This education should extend to family members and partners to foster a supportive environment for the mother's recovery. Nurses should emphasize the importance of seeking professional help if symptoms worsen or do not improve with time. Additionally, nurses can educate mothers about the importance of seeking help from mental health professionals, such as therapists or psychiatrists, and can facilitate referrals to these services. Providing information on community resources, such as support groups for new mothers, can help women feel less isolated and more connected to others experiencing similar challenges.

Collaboration and Follow-up Care

Collaboration with other healthcare professionals is essential in managing PPD. Nurses should communicate with physicians, mental health specialists, and social workers to develop a holistic care plan for the mother. In some cases, psychiatric medications, such as antidepressants or therapy, may be necessary to manage symptoms effectively. Nurses must monitor the mother's response to treatment, checking for any side effects or changes in her condition that may require adjustments in her care plan. Follow-up care is a critical component of nursing interventions for PPD. Nurses should schedule regular check-ins with the mother, either through home visits or telehealth services, to monitor her progress and address any concerns. This ongoing support helps to ensure that the mother is receiving the care she needs and allows for early intervention if symptoms worsen. A comprehensive nursing intervention plan for postpartum depression must include thorough assessment, emotional support, education, and collaboration with other healthcare providers. Nurses play a vital role in identifying PPD early, providing emotional and psychological support, and ensuring that the mother has access to the resources and treatments necessary for recovery. By providing holistic, patient-centered care, nurses can significantly improve the outcomes for mothers with postpartum depression and promote overall maternal well-being.

Conclusion:

Postpartum depression (PPD) is a serious mental health condition that can significantly affect the well-being of both the mother and her infant. The disorder often goes undiagnosed, leading to prolonged suffering for the mother and potential developmental risks for the child. Nurses are integral to the management and care of individuals with PPD, playing a key role in early detection, intervention, and support. Routine screening using tools like the Edinburgh Postnatal Depression Scale (EPDS) is vital for identifying those at risk. Nurses' ability to identify symptoms of PPD early allows for timely referrals to mental health professionals, ensuring that patients receive appropriate care. In addition to screening, nurses provide essential support by offering psychoeducation, promoting social support, and addressing the emotional needs of postpartum individuals. Providing mental health education and facilitating the development of coping mechanisms helps reduce the stigma surrounding PPD, making it easier for individuals to seek help. Interventions such as counseling, cognitive behavioral therapy, and interpersonal therapy, in combination with pharmacological treatment when necessary, contribute to effective management of the condition. Furthermore, ensuring that PPD care is integrated into routine postpartum care enhances the accessibility and efficiency of mental health services for new parents. Training and education for nurses on mental health issues are critical to improve care delivery. Equipping nurses with the knowledge and skills to address postpartum depression will ensure they are more effective in their roles. Ongoing professional development in mental health care can enhance the detection and management of PPD, leading to better maternal and child health outcomes. Overall, the role of nurses in postpartum depression care is crucial. They are at the forefront of maternal healthcare, providing essential screenings, interventions, and support to individuals at risk of PPD. By addressing the emotional and psychological needs of new mothers, nurses can significantly improve recovery outcomes and contribute to healthier family dynamics.

References:

1. Serati M, Redaelli M, Buoli M, Altamura AC. Perinatal Major Depression Biomarkers: A systematic review. J Affect Disord. 2016 Mar 15;193:391-404.
2. Justesen, K., & Jourdaine, D. (2023). Peripartum Depression: Detection and Treatment. *American family physician*, *108*(3), 267-272.

3. Liu X, Wang S, Wang G. Prevalence and Risk Factors of Postpartum Depression in Women: A Systematic Review and Meta-analysis. J Clin Nurs. 2022 Oct;31(19-20):2665-2677.
4. Valdes EG, Sparkman L, Aamar R, Steiner L, Gorman JM, Ittel V, Bethea JJ, Reist C. Improving maternal mental health: assessing the extent of screening and training about peripartum depression. J Matern Fetal Neonatal Med. 2023 Dec;36(1):2155042.
5. Zauderer C. Postpartum depression: how childbirth educators can help break the silence. J Perinat Educ. 2009 Spring;18(2):23-31.
6. Konjevod M, Gredicak M, Vuic B, Tudor L, Nikolac Perkovic M, Milos T, Svob Strac D, Pivac N, Nedic Erjavec G. Overview of metabolomic aspects in postpartum depression. Prog Neuropsychopharmacol Biol Psychiatry. 2023 Dec 20;127:110836.
7. Ghaedrahmati M, Kazemi A, Kheirabadi G, Ebrahimi A, Bahrami M. Postpartum depression risk factors: A narrative review. J Educ Health Promot. 2017;6:60.
8. Zacher Kjeldsen MM, Bricca A, Liu X, Frokjaer VG, Madsen KB, Munk-Olsen T. Family History of Psychiatric Disorders as a Risk Factor for Maternal Postpartum Depression: A Systematic Review and Meta-analysis. JAMA Psychiatry. 2022 Oct 01;79(10):1004-1013.
9. Hutcherson TC, Cieri-Hutcherson NE, Gosciak MF. Brexanolone for postpartum depression. Am J Health Syst Pharm. 2020 Feb 19;77(5):336-345.
10. Carlini, S. V., Osborne, L. M., & Deligiannidis, K. M. (2023). Current pharmacotherapy approaches and novel GABAergic antidepressant development in postpartum depression. *Dialogues in Clinical Neuroscience*, *25*(1), 92-100.
11. Couto TC, Brancaglion MY, Alvim-Soares A, Moreira L, Garcia FD, Nicolato R, Aguiar RA, Leite HV, Corrêa H. Postpartum depression: A systematic review of the genetics involved. World J Psychiatry. 2015 Mar 22;5(1):103-11.
12. Meltzer-Brody S. New insights into perinatal depression: pathogenesis and treatment during pregnancy and postpartum. Dialogues Clin Neurosci. 2011;13(1):89-100.
13. O'Hara MW, McCabe JE. Postpartum depression: current status and future directions. Annu Rev Clin Psychol. 2013;9:379-407.
14. Cardaillac C, Rua C, Simon EG, El-Hage W. [Oxytocin and postpartum depression]. J Gynecol Obstet Biol Reprod (Paris). 2016 Oct;45(8):786-795.
15. Treatment and Management of Mental Health Conditions During Pregnancy and Postpartum: ACOG Clinical Practice Guideline No. 5. Obstet Gynecol. 2023 Jun 01;141(6):1262-1288.
16. Screening and Diagnosis of Mental Health Conditions During Pregnancy and Postpartum: ACOG Clinical Practice Guideline No. 4. Obstet Gynecol. 2023 Jun 01;141(6):1232-1261.
17. Lakkis NA, Mahmassani DM. Screening instruments for depression in primary care: a concise review for clinicians. Postgrad Med. 2015 Jan;127(1):99-106.
18. Beck CT. Postpartum depression: it isn't just the blues. Am J Nurs. 2006 May;106(5):40-50; quiz 50-1.
19. Powell JG, Garland S, Preston K, Piszczatoski C. Brexanolone (Zulresso): Finally, an FDA-Approved Treatment for Postpartum Depression. Ann Pharmacother. 2020 Feb;54(2):157-163.
20. Kanes S, Colquhoun H, Gunduz-Bruce H, Raines S, Arnold R, Schacterle A, Doherty J, Epperson CN, Deligiannidis KM, Riesenberg R, Hoffmann E, Rubinow D, Jonas J, Paul S, Meltzer-Brody S. Brexanolone (SAGE-547 injection) in post-partum depression: a randomised controlled trial. Lancet. 2017 Jul 29;390(10093):480-489.
21. Meltzer-Brody S, Colquhoun H, Riesenberg R, Epperson CN, Deligiannidis KM, Rubinow DR, Li H, Sankoh AJ, Clemson C, Schacterle A, Jonas J, Kanes S. Brexanolone injection in post-partum depression: two multicentre, double-blind, randomised, placebo-controlled, phase 3 trials. Lancet. 2018 Sep 22;392(10152):1058-1070.
22. Deligiannidis KM, Meltzer-Brody S, Maximos B, Peeper EQ, Freeman M, Lasser R, Bullock A, Kotecha M, Li S, Forrestal F, Rana N, Garcia M, Leclair B, Doherty J. Zuranolone for the Treatment of Postpartum Depression. Am J Psychiatry. 2023 Sep 01;180(9):668-675.

23. Senda M, Johnson K, Taylor I, Jensen M, Flynn H, Kozel FA. Accelerated Transcranial Magnetic Stimulation Provided Rapid Improvement in Depressive, Anxiety, Trauma, and Pain Symptoms in a Woman Experiencing Postpartum Depression. J ECT. 2023 Sep 01;39(3):e14-e15.
24. Milgrom J, Gemmill AW, Ericksen J, Burrows G, Buist A, Reece J. Treatment of postnatal depression with cognitive behavioural therapy, sertraline and combination therapy: a randomised controlled trial. Aust N Z J Psychiatry. 2015 Mar;49(3):236-45.
25. Stewart DE, Vigod SN. Postpartum Depression: Pathophysiology, Treatment, and Emerging Therapeutics. Annu Rev Med. 2019 Jan 27;70:183-196.
26. Yonkers KA, Vigod S, Ross LE. Diagnosis, pathophysiology, and management of mood disorders in pregnant and postpartum women. Obstet Gynecol. 2011 Apr;117(4):961-977.
27. Robakis TK, Williams KE. Biologically based treatment approaches to the patient with resistant perinatal depression. Arch Womens Ment Health. 2013 Oct;16(5):343-51
28. Anderson EL, Reti IM. ECT in pregnancy: a review of the literature from 1941 to 2007. Psychosom Med. 2009 Feb;71(2):235-42.
29. Chechko N, Stickel S, Votinov M. Neural responses to monetary incentives in postpartum women affected by baby blues. Psychoneuroendocrinology. 2023 Feb;148:105991.

دور الممرضات في رعاية اكتئاب ما بعد الولادة - مراجعة محدثة

الملخص:

الخلفية: يعد اكتئاب ما بعد الولادة (PPD) اضطرابًا مزاجيًا كبيرًا يؤثر على الأفراد في السنة الأولى بعد الولادة. إنه يشكل مصدر قلق صحي عام كبير لأنه يمكن أن يؤثر بشكل كبير على قدرة الأم على العناية بنفسها وطفلها، مما يؤدي إلى مشاكل تنموية طويلة الأمد للطفل. تشمل أعراض PPD الحزن المستمر، والقلق، واضطرابات النوم، وغالبًا ما تؤدي إلى ضعف التواصل مع الطفل. يعد الاكتشاف المبكر والعلاج أمرين حاسمين للوقاية من النتائج السلبية. تلعب الممرضات دورًا حيويًا في الفحص والدعم وإدارة الرعاية للأفراد الذين يعانون من.PPD

الهدف: تهدف هذه المراجعة إلى استكشاف دور الممرضات في رعاية وإدارةPPD ، مع التركيز على الاكتشاف المبكر، والفحص، واستراتيجيات التدخل. كما تبحث في أهمية التعليم التمريضي ودمج الرعاية الصحية النفسية في الرعاية الروتينية بعد الولادة.

الطرق: تم إجراء مراجعة أدبيات محدثة لجمع الدراسات والأدلة ذات الصلة حول أدوار الممرضات في إدارة .PPD تشمل المجالات الرئيسية التي تم استكشافها أدوات الفحص، والتدخلات العلاجية، وأثر دعم التمريض على نتائج المرضى. تم تحليل المقالات من إرشادات الممارسة السريرية، والمراجعات المنهجية، والبحوث الأولية لتوفير فهم شامل للأدلة الحالية.

النتائج: تعد الممرضات أساسيين في التعرف على أعراض PPD من خلال الفحوصات الروتينية مثل مقياس اكتئاب ما بعد الولادة في إدنبرة .(EPDS) يمتد دورهن إلى ما بعد الفحص ليشمل توفير الدعم العاطفي، والتعليم، والإحالة إلى المتخصصين في الصحة النفسية. تحسن التدخلات التمريضية، بما في ذلك التثقيف النفسي، والإرشاد، وتعزيز الدعم الاجتماعي، بشكل كبير من نتائج الصحة النفسية للأمهات. بالإضافة إلى ذلك، يعد دمج الرعاية الصحية النفسية في الرعاية الروتينية بعد الولادة أمرًا حاسمًا لإدارة PPD بشكل فعال.

الخلاصة: للممرضات دور حيوي في الاكتشاف المبكر والدعم وإدارة .PPD إن دمج الرعاية الصحية النفسية في الزيارات الروتينية بعد الولادة وتوفير الرعاية التمريضية الشاملة يمكن أن يحسن رفاهية الأم والطفل. إن التعليم والتدريب المستمر للممرضات أمران أساسيان لتعزيز دورهن في معالجة.PPD

الكلمات المفتاحية: اكتئاب ما بعد الولادة، دور الممرضات، الفحص، التدخل، مقياس اكتئاب ما بعد الولادة في إدنبرة، الصحة النفسية، الرعاية بعد الولادة.