



Postpartum Depression In Adolescent Mothers: Promised Interventions And Outcomes

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Abstract

Adolescent mothers have a greater risk for have postpartum depression (PPD). In addition, most of the adolescent mothers had a lack of social support and insufficient funds and acknowledgment. Moreover, PPD can lead to a significant direct effect on not just the patient yet, it will affect the new born, families, and the community also. Therefore, is essential to have them treated and required for effective intervention to prevent postpartum depression. The aim of this article is to discover the use of intervention tools applied for the patient and meets patient satisfaction treatment outcomes. Furthermore, this review also aims to illustrate the etiology, epidemiology, incident, risk factors, complication, and treatment for adolescent mothers who are likely to have PPD. In summary, more research about this topic to establish the treatment criteria are required to assist adolescents who suffer from this global issue that might significantly be a major impact on society.

Keywords: Adolescent, Depression, Postpartum, Adolescent mother, intervention

Introduction

Nowadays, the globe has seen an increase in the number of young mothers, and the majority of them have experienced mental health issues such as stress and anxiety, which can result in depression (1, 2). The issue can be triggered by various risk factors, including marital status, socioeconomic level, a lack of social support, familial pressure, peer pressure, and a lack of information (3). Similarly, when compared to real-world situations, those risk variables can significantly impact the development of the most severe stressors among young moms worldwide (4-6). Additionally, the effects of PPD, such as grief, low self-esteem, desperation, meaninglessness, isolation, tearfulness, poor sleep pattern; insomnia, lack of enthusiasm, loss of appetite, are significant risks that affect both mental and physical health, interfering with the adolescent mother and potentially fatal for an adolescent who had a suicidal idea (7). That dangerous ailment impacts her and their infant and their loved one.

According to a recent study, adults have a lower likelihood of developing PPD than adolescents. Furthermore, teenagers had elevated PPD rates of between 15% to 50%, compared to adults who had a rate of 10% (2). This review aims to explore the promised interventions to deal with postpartum depression in adolescent mothers as well as the outcomes from the interventions.

Postpartum depression (PPD)

Nowadays, the rate of adolescent pregnancy had significantly increased over the century. Initially, the adolescent mother could not avoid the fact to be encountered through the entire nine months of pregnancy with involved both physical and psychological change (8). Especially for major hormonal changes will be a direct effect on emotional therefore the pregnancy would have unstable mood affect and be more sensitive, moreover this risk will also affect people surroundings such as their partner, family, peer group, and community (3, 4). In

addition, during the postpartum period, the women may experience symptoms of “postpartum blues” such as sadness, tearfulness and it will last for two weeks (7).

In comparison, women can be developed postpartum depression (PPD) which will be last after one-sixth months after the delivery of the baby. Women with PPD will have symptoms of extreme fatigue, emptiness, worthlessness, inability to stop crying, extreme mood fluctuations, and etc. In the contrast, postpartum blue will be last quicker than women with PPD and had higher severity (6, 7). Despite this, it can cause brain response among maternal who have postpartum depression which will be a direct effect on behaviour related to a component of the brain that are compromised. Although there are many cases of maternal with PPD yet a half of them were undergone diagnostic, whereas the rest of the cases may have a stigma, lack of supportive factors, or being abandoned (8). However, the mother with PPD may have reasons for instance conflict in privacy or they don't explore the issues with family. As well as in any trimester of pregnancy, women have both depression and anxiety risks which can lead to postpartum depression (9, 10).

Risk Factors

Patient history of depression and anxiety is a significant risk (11). Moreover, premenstrual syndrome (PMS), maternal negative attitude toward child, dissatisfaction of child gender, women who have a history of sexual abuse had a greater risk to develop PPD (12-14). The risk from pregnant women such as the emergency cases for caesarean section and hospitalisation (15-17). In addition, pregnant women may face another risk while pregnant that may develop risks which include meconium strain, preterm infant, low birth weight new-born, prolapse cord, an infant with low haemoglobin (18-20). Social support is important to serve a mother without that support it can cause postpartum depression (21). The important causative factors include spouse sexual harassment and physical violence and verbal abuse, those are domestic violence that can develop the disease (22). Furthermore, women who smoke during pregnancy are at risk factors to develop postpartum depression as well (23, 24).

Sedentary lifestyle which includes poor nutrition, unusual sleep patterns, inappropriate physical activity, and exercise are directly affect the disease (25, 26). Vitamin B6 is a conversion to tryptophan and serotonin which affects moods and involved postpartum depression (27). Maternal unusual sleep patterns are a risk factor to develop depression (28). It can be evident that the women with postpartum depression had decreased sleep. Physical activity and exercise can develop self-esteem, self-confidence, increase problem-solving skills, improve focus, and can also decrease depressive symptoms (29). Exercise stimulates endorphins production and opioids that may bring a positive effect on mental health (26).

Therapy-based intervention

Pharmacological Treatment

Psychotherapy and antidepressant medicine are the first-line treatments for peripartum depression (30). Women with peripartum depression in the range of mild to moderate should initially consider psychosocial and psychological counseling, especially if they plan to nurse their newborns (31). For women with depressive symptoms of moderate to severe, a combination of treatment and antidepressant medication is advised (32). The first line of defense is selective serotonin reuptake inhibitors or known as SSRI (33). If the SSRI is not effective, consider switching to mirtazapine or serotonin-norepinephrine reuptake inhibitors (SNRIs). Once an effective dose has been established, the continuum of treatment should be six to twelve months in order to avoid a return of symptoms (34). Pharmacologic advice for nursing women should include discussions on the advantages of breastfeeding, and the dangers that may be associated with the use of antidepressants during lactation, and the risks factors associated with the disease that not have been treated. Breastfeeding mothers concerned about their newborns being exposed to drugs may find relief with repetitive transcranial magnetic stimulation (TMS) (35, 36). Sertraline has the most evidence for its use in preventing and treating postpartum depression (33). Breastfeeding is primarily risk-free while on an inhibitor of serotonin reuptake, and the mother may encourage to breastfeed and be on a group of antidepressants medication (37).

Psychological And Psychosocial Treatments

According to worries that may be related to the exposure of medication among infancy throughout maternal breast milk or the concern of potential adverse effects, there are several mothers who suffer from postpartum depression who are unwilling to take medication like antidepressants, and psychosocial therapy is frequently preferred over pharmaceutical treatments (38). There have been few systematic investigations into nonpharmacologic treatments for women with PPD, on the other hand, there is evidence to date to support the treatment by using both psychological (psychodynamic psychotherapy and particularly cognitive-behavioral therapy), in the same way as the intervention of psychosocial, for instance, nondirective counselling (39). For postpartum depression, a Cochrane meta-analysis including 10 randomized controlled trials found that the interventions involved psychosocial and psychological were successful in lowering depression and were feasible therapy choices (40).

Cognitive-Behavioural Therapy (CBT)

Cognitive-behavioural therapy or CBT is an alternative treatment for a major depressive disorder which is well known for being the best studied and effective treatment, it can be predicted by the premise that the human mood is intimately linked by behaviours and perceptions (41, 42). CBT plays a key role in assisting the patient with depression by modifying patterns of distortion negative thought and the implementation of behavioural changes that can wisely gain the improvement of coping and the reduction of distress (42, 43). Numerous trials have been conducted to evaluate CBT only in the same way with the combination of other interventions to treat postpartum depression. When Appleby and her team did a randomized controlled psychotherapy-pharmaceutical study, they divided up 87 women who had PPD into one of four groups, each a counselling session of one or six CBT-based and either placebo or fluoxetine (42, 43). Each of 4 groups of treatment experienced that depressive symptoms had significantly gradually reduced (43). Moreover, the more reduction of depressive symptoms resulted in CBT sessions six times versus one resulted (44). Six sessions of cognitive-behavioural therapy along with a placebo pill show

the effectiveness of fluoxetine with one session of cognitive-behavioural therapy, on the other hand, there were without added advantages in the group receiving six counselling sessions in order of the addition to fluoxetine (42, 45, 46).

Peer And Partner Support

According to lacking social support is one of the important risk factors to enhance postpartum depression, additionally the epidemiologic data and some studies that looked at people who were going to be pregnant at the time (47, 48). Thus, the key point to be considered is interventions that may increase social support by treatment options, especially for perinatal depression. Both of the prenatal and postnatal periods that lack support was linked to a higher risk of PPD founded that evidenced by people who were pregnant at the time the study was done, however, the highest risk of women during the postpartum period who did not have a lot of objective or practical support after they gave birth (49, 50).

Electroconvulsive Therapy

Besides medication that involved antidepressants, there is an alternative treatment called electroconvulsive therapy (ECT) which is suit for patients who are not responding to medication and had severe depressive symptoms (51, 52). A study found 5 postpartum depression women who received ECT had reported a 100% of remission rate. For modified ECT type anaesthesia is required and had a no different effect as well as in major depression (53, 54). In the same way, the minimizing of time in breastfeeding can reduce the risk of transmission in breastfeeding from the use of anaesthetic agents used in ECT (55).

Bright Light Therapy

The research found that therapy in bright light is another beneficial treatment for seasonal affective disorders, the bright light therapy is the initial treatment for nonseasonal depression. There is no evidence to support a risk from Light therapy among fetuses and nursing infants. Meanwhile, there is insufficient data to support whether the therapy is effective in postpartum women (56). Daily in six weeks, bright light (10,000 lux, n = 10) or dim red light (600 lux, n = 5) were randomly used among 15 maternal who experiencing PPD in an outpatient

department that was conducted in one study (57-59). According to the small sample size, the study was unable to specify the effectiveness of treatment information related to light therapy. However, all measurements of depression were gradually improved among both groups. The effectiveness of light therapy is required to clarify more in further studies among PPD (58).

Omega-3 Fatty Acids

Omega-3 fatty acids possess garnered particular feedback in treating depression among the perinatal group due to their well-documented health advantages for both women who are currently pregnant and who are in the postpartum period (60, 61). Certain studies indicate that these molecules have a favourable influence on the mood in the general population (62). Omega-3 fatty acids are commonly found in fish oils, such as EPA also known as eicosapentaenoic acid, and docosahexaenoic acid or DHA, which are critical building blocks for developing a central nervous system among babies in gestation, moreover, this process is facilitated by decreasing omega-3 fatty acids among mother throughout pregnancy (62). There are cross-national studies often referenced found that consumption of each capita fish can inversely be associated with a chance of severe depression development (63). Additional evidence from epidemiologic supports a link of poor consumption of omega-3 fatty acid from seafood and an increased chance of experiencing symptoms of severe depression during pregnancy (64, 65). In spite of these epidemiological correlations, research on the treatment of omega-3 fatty acids for depression in prenatal has produced inconsistent outcomes (66). According to Freeman *et al.* that have been conducted for two pilot studies on a treatment from omega-3 fatty acids who perinatal women who have depression; the first was established on open-label, a combination of flexible-dose of EPA and DHA for MDD treatment during pregnancy, secondly, it was an 8-week by randomizing the dose-ranging of the study by evaluating the efficacy of postpartum depression that has been treated by omega-3 fatty acids used (67).

To summarize, there are effects of therapeutic effects on prenatal depression from omega-3 fatty acids.

However, recent studies examined the impact that using small sample sizes. Various studies established the dietary consumption as omega-3 fatty acids among individuals that study participation shows the low prior (63). Omega-3 fatty acids provide several obvious benefits to health for the mother and fetal development or nursing care of newborns (62). Notably, although omega-3 fatty acids can prolong the timing of bleeding at the higher doses, recently a study found that omega-3 fatty acids at 3–4 g/day of doses, by clinical had no significant effect on the times of bleeding or the possible events of bleeding among the patients who have cardiovascular disease and who were received antiplatelet therapy (64).

Conclusion

Over the century postpartum depression associated with a global public health issue among maternal and infancy at least 1 in 8 mothers after childbirth. In resource-poor countries, there are more morbidity rates among both maternal and child and postpartum depression becomes more common. Moreover, there is a negative effect on children such as physical, cognitive, and emotional development which is not just a direct effect on the mother. Importantly, mitigation of mentioned risk may be minimized by early detection and intervention. Nowadays, the availability of assessment in numerous translated languages for instance the Edinburgh Postnatal Depression Scale, in addition, this scale is the majority validated tool recommended for screening women with PPD that required 4-6 weeks after childbirth. Although few drug trials have been conducted to evaluate the efficacy for both ECT therapy or antidepressant medication in PPD, evidence that existed was suggested that pharmacologic treatment commonly aims to generally relieve major depression patients which is also advantageous in PPD as well. In its entirety pharmaceuticals enter expanded to breast milk in varying degrees, additionally nortriptyline, paroxetine, and sertraline being considered the most safety way profiles in breastfeeding. Although those pharmaceuticals have been reports of antidepressant medication added in breast milk having detrimental effects on nursing infants, the benefits of breastfeeding for both women and her newborn would outweigh the dangerous exposure. There are alternative treatments for postpartum depression

known as psychological treatments that are frequently wisely treatment choices for mothers inasmuch they successfully alleviate depression symptoms without exposing women to medication-related dangers. Psychotherapy and other psychosocial therapies have been shown in research to reduce PPD symptoms. Additionally, psychotherapy for interpersonal, psychotherapy in psychodynamic, therapy of cognitive-behavioral, and many more effective therapies, for instance, peer support by telephone-based, counseling by a health visitor, and the supportive by a partner that has all demonstrated superiority, as usual, controlling of care. Furthermore, non-pharmacologic therapies including therapy of bright light used, supplementary products such as omega-3 fatty acid, and exercise were investigated for treating postpartum depression. Although the effectiveness among modalities data shows the reducing symptoms of postpartum depression that are scarce, All of the therapies above had to carry negligible risks and possibly enhance both mother and new-born health.

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