

# Efficiency of Psychological Approaches in Case of Postpartum Depression in Primary Care

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**Abstract:** Postpartum depression (PPD) is common, reported to be experienced by 15% or more of women during the 12 months after they giving birth to their infants. This review was aim to discuss the role of primary care (Family physicians) in the psychological management of postpartum depression, to be able to evaluate this point we need to overview the diagnostic approaches of PPD in primary care and the awareness general physicians (GPs) about the symptoms and how to approach the treatment of women with PPD. We conducted this review by searching published literature in the following databases: MEDLINE/PubMed, and the Cochrane Central Register of Controlled Trials through “December, 2016”. Reference lists of other relevant publications were screened to identify additional potentially relevant studies that were not identified by the first method of literature searches. The evidence we consisted of in this analysis targeted mainly postpartum women depression management and diagnosis in medical care and the functions of family doctor in management of PPD. The little proof found concerning pregnant females suggested equivalent effects with postpartum ladies for advantages of screening, accuracy of the EPDS, the indirect evidence revealed that screening instruments can identify pregnant and postpartum ladies who require additional evaluation and may require treatment.

**Keywords:** Postpartum depression (PPD), postpartum depression.

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## 1. INTRODUCTION

Postpartum depression (PPD) is common, reported to be experienced by 15% or more of ladies during the 12 months after they deliver<sup>(1,2,3)</sup>. Regardless of nearly universal health care encounters at some time during this duration, just about 50% of ladies with substantial depressive symptoms are acknowledged<sup>(4,5)</sup>. PPD occurs among ladies of all ages, parities, races, and socioeconomic groups<sup>(6,7)</sup>. Unresolved and unattended PPD negatively affects the woman, her infant and her relationship with relative<sup>(8,9)</sup>. For that reason, universal screening for PPD is an attractive method, and numerous groups have made recommendations concerning universal PPD screening in the medical care setting<sup>(2,10,11)</sup>. Price quotes of prevalence of PPD in the US, UK and Australia vary from 7% - 20%, with many studies suggesting rates in between 10% - 15%<sup>(12,13)</sup>. Considerable risk factors for PPD include a history of depression prior to or during pregnancy, anxiety during pregnancy, experiencing demanding life events during pregnancy or the early puerperium, low levels of social assistance or partner support, low socioeconomic status, and obstetric complications<sup>(13)</sup>. The significant unfavorable impact of PPD for mothers, infants, and their families has been developed<sup>(14)</sup>. Skilled maternal function is seriously essential for making sure the infant's safety and wellness. Difficult character, bad self-regulation and behavioral problems have actually been observed in infants of depressed mothers<sup>(15)</sup>. The depressed mom may not experience a gratifying and favorable relationship with her infant, which serves to balance out the stresses of newborn care and postpartum recovery<sup>(16)</sup>. Maternal depression that disrupts the relationship between the mother and her infant contributes to a higher risk for poor infant and child developmental outcomes<sup>(16)</sup>. Offered the proof for the effectiveness of both medicinal and psychological interventions in enhancing health results when PPD is identified, there is much to be gotten from early recognition and management in medical care. Guidelines from the National Institute for Health and Clinical Excellence (NICE)<sup>(17)</sup> advise that mild to moderate signs need to be handled within primary care, with mental treatments as a first-line treatment.

GOOD standards<sup>(17)</sup> also advise a lower seriousness threshold for treatment in the perinatal duration due to the proof for adverse, long-lasting effects on infant and child health and wellbeing.

This review was aim to discuss the role of primary care (Family physicians) in the psychological management of postpartum depression, to be able to evaluate this point we need to overview the diagnostic approaches of PPD in primary care and the awareness general physicians (GPs) about the symptoms and how to approach the treatment of women with PPD.

## 2. METHODOLOGY

We conducted this review by searching published literature in the following databases: MEDLINE/PubMed, PsycINFO, and the Cochrane Central Register of Controlled Trials through “December, 2016”. Reference lists of other relevant publications were screened to identify additional potentially relevant studies that were not identified by the first method of literature searches. One main term was used in our search; “postpartum depression” and was combined with different terms such: diagnostic methods, screening programs, primary care, family physicians. we restricted our search for only English published articles with human subject, and we included all study types RCTs, reviews, systematic reviews, meta-analysis, except for case reports studies we excluded this from our search.

## 3. RESULTS

### o Roles of primary care physicians (Family Physicians) in diagnostic of PPD, and its benefits:

In this review we intended mainly to answer the following question! Do primary care has an effective role in diagnostic management approaches for postpartum women which can result in improved health outcomes (decreased depressive symptomatology; decreased suicide deaths, attempts, or ideation; improved functioning; improved quality of life; or improved health status?

The recently released King's Fund term paper on the role of general physicians (GPs) in maternity care<sup>(18)</sup> appropriately asks the question of whether the pattern to wear down the role of GPs in maternity services will influence on care quality for perinatal mental healthcare. Although presently 83% of women still check out the GP when pregnancy is determined<sup>(19)</sup>, increasingly they are encouraged to bypass the GP to book directly with a midwife. This technique positions some obstacles.

The GP is the one professional with access to a complete and current history for each lady, and the communication of this pertinent history might save lives. The Confidential Enquiry into Maternal Deaths<sup>6</sup> discovered that in cases resulting in suicide, previous psychiatric history was typically not interacted between health care professionals. Women might be unpleasant divulging a history of severe psychological health issues, and midwives do not get training to determine intricate or unusual psychological health issues. GPs are well positioned to raise awareness of PPD with pregnant females, screen psychological health status during pregnancy, spot early signs of PPD, and make urgent recommendations to specialist secondary care services if serious mental disorder is suspected<sup>(18,19)</sup>.

### Screening methods:

Several studies in United States discussed and evaluated the international programs have attempted to execute universal postpartum depression screening with or without follow-up care in family medicine. Some programs have actually consisted of formal examinations, but few have led to improved patient results<sup>(20,21,22,23)</sup>. Evaluations by a number of evidence-based standard groups have reported undetermined or insufficient info regarding enhanced results with PPD screening, avoiding them from suggesting universal PPD screening. While these evaluations offer summary evaluations, they fail to assess program design, context, setting, or parts of the program as potential factors affecting success or failure<sup>(2,3,4,11)</sup>.

In this review Six trails were included that examined the benefits of evaluating for postpartum and pregnant depression (n=11 869)<sup>(24,25,26,27,28,29)</sup> with or without additional clinician training or treatment components. Five trials focused on postpartum women<sup>(24,25,27,29)</sup>, and the sixth focused on pregnant ladies<sup>(28)</sup>. All trials studied women determined in health care settings and included all study-eligible ladies despite evaluating test outcomes. 2 trials consisted of unscreened control groups<sup>(26,27)</sup>, and 4 screened all individuals but sent out results to just the intervention group's clinicians<sup>(24,25,28,29)</sup>. Trials screened ladies at week 25 of pregnancy<sup>(28)</sup> or 4 to 8 weeks postpartum. Only 1 trial was carried out in the United States<sup>(25)</sup>. Both of the separately randomized trials left out females who were presently being dealt with for depression

<sup>(25,26)</sup>; however, the trials that randomized at the level of a midwife or medical practice all had really broad inclusion criteria and did not omit ladies being dealt with for depression. All research studies utilized the Edinburgh Postnatal Depression Scale (EPDS) (**discussed in details below**) for screening; cutoffs for screening positive varied from 10 to 13. While 1 trial focused narrowly on the advantage of adding the EPDS to the typical medical evaluation <sup>(24)</sup>, others provided a large range of parts in addition to the screening intervention, such as clinician training and support, person-centered therapy, or revamped follow-up care.

#### **Edinburgh Postnatal Depression Scale (EPDS):**

The most common measure to screen for depression related to childbearing is the EPDS in primary care. This self-report instrument consists of 10 items ranked from 0 to 3 that show the patient's experience over the past week. The EPDS has actually been confirmed thoroughly for use in the postpartum period and during pregnancy.

The most typical approach reported by physicians to determine maternal depression is their reliance on overall impression of the mother and consists of recognition of appearance, such as flat affect, or behavior, such as withdrawal <sup>(30,31,32)</sup>. When physicians utilize this technique in adult medical care settings, however, they cannot acknowledge 38% of patients later identified with depression based on the Diagnostic Interview Schedule (DIS) <sup>(33)</sup>. In a research study performed in an inner city basic pediatric center, Heneghan et al. <sup>(34)</sup> revealed that pediatric healthcare providers recognized less than 30% of mothers who scored favorable for depression on the Psychiatric Symptom Index, a self-completed survey (34,35). The Edinburgh Postnatal Depression Scale (EPDS) was developed by Cox et al. <sup>(36)</sup> in 1987 to recognize mothers, throughout the postpartum duration, who required additional evaluation for depression. Each item on this 10-item questionnaire is ranked on a four-point scale (0 - 3), with amount scores ranging from no to 30. With the Research Diagnostic Criteria as gold standard <sup>(37)</sup>, the EPDS demonstrated a level of sensitivity of 86% and an uniqueness of 78% <sup>(36,38,39,40)</sup>. Given that its introduction, EPDS has actually been equated into many languages and confirmed and utilized throughout the world as an extremely trusted screening tool for postpartum depression <sup>(41)</sup>. In a study of EPDS usage in a pediatric setting, Chaudron et al. <sup>(42)</sup> documented boosts in detection of depression during well child care from 1.6 to 8.5% and in mental health referrals from 0.2 to 3.6%. The intent of the practice intervention was to institute universal depression screening, EPDS forms were collected and included in the medical records in only 46% of the child healthcare. When EPDS kinds were recognized, however, 88% had actually been successfully completed <sup>(42)</sup>. The outcomes most applicable to US medical care come from a fair-quality United States trial of screening plus clinician assistances <sup>(29)</sup>. Forty-five percent of intervention individuals reported a 5-point or greater drop in their PHQ-9 ratings, the a priori definition of scientific meaningful advantage, whereas 34% of those receiving typical care reported such a drop (odds ratio [OR], 1.74 [95% CI, 1.05-5.86], adjusted for depression history, marital status, earnings, education, age, and degree of parenting tension). This trial was ranked as fair primarily since attrition was greater than 25% in both groups, which was a common issue in the studies on the benefits of evaluating for depression <sup>(29)</sup>.

#### **Other diagnostic method for PPD in primary care:**

The Center for Epidemiologic Studies of Depression instrument (CES-D) is a 20-item questionnaire; ratings  $\geq 16$  show depression based on symptoms in the last 7 days. CES-D scores remain stable in the first year postpartum and are related to the diagnostic status of depressive conditions <sup>(43)</sup>. The CES-D has been used extensively to screen for depression in culturally varied populations <sup>(43)</sup> and teen moms (high level of sensitivity and specificity) <sup>(44)</sup>.

The 9-item depression module of the Patient Health Questionnaire (PHQ-9) <sup>(45)</sup> is another common screening step. Reactions at 4 levels (not, a number of days, more than half the days and almost every day) apply to how the patient has actually felt in the past 2 weeks. The complete PHQ and the PHQ-9 (brief version) efficiently identified patients with and without major depression in primary care and obstetrical settings <sup>(45)</sup>. The high sensitivity (88%) and specificity (88%) ensure the credibility of the PHQ for recognizing depression risk <sup>(45)</sup>. However, additional recognition data are required for the examination of postpartum patients <sup>(46)</sup>.

The Postpartum Depression Screening Scale (PDSS) <sup>(47)</sup> evolved from qualitative interviews to explore the maternal experience after childbirth. 7 items comprise the initial screening; patients with PDSS  $\geq 14$  received an extensive survey of 28 extra items. Ratings  $\geq 60$  suggest risk for significant or minor depression; ratings  $\geq 80$  are highly predictive of significant depression <sup>(47)</sup>.

o **The roles of Family Physicians in treatment of PPD:**

The main goals of improving perinatal mental healthcare should be to decrease the effect of psychiatric symptoms on the next generation; lower the distress triggered to women and their households; and to address maternal suicide rates. Decreasing maternal suicide rates requires all healthcare experts in contact with ladies in the postnatal period to be alert to self-destructive ideation, hopelessness, and the signs of severe mental illness.

Screening alone has not been shown to enhance patient outcomes and might be dishonest<sup>(48,49)</sup>. Handling PPD is restricted to adding 10 concerns to a patient care see. Even a negative screening result requires some discussion. A positive screening result should set off a waterfall of events that alter the see material and practice work circulation. Practice tools are needed to assist in these modifications. Olson and her coworkers have actually established a set of tools to facilitate the intro and execution of regular PPD and maternal depression screening into pediatric practices. The info is readily available on a site<sup>(50)</sup> and has actually been extensively distributed through an American Academy of Pediatrics Task Force report<sup>(51)</sup>. Yawn et al. likewise developed primary care particular tools to support diagnosis, medication therapy initiation, and PPD follow-up and monitoring plan<sup>(29)</sup>. Programs that support practice system modifications such as universal PPD screening appear to take advantage of regional education and assistance for the practice modification and its application. Without tools and support for system change, dissemination is likely to be slow with each practice reinventing comparable work education, circulation and support systems<sup>(52)</sup>.

Four research studies did report patient results, 2 without enhancement (New Haven and New Jersey)<sup>(22,53)</sup> and two with enhanced outcomes (Hong Kong and United States family physicians)<sup>(26,29)</sup>. 2 important elements that appear to separate not successful and successful programs are the capability to provide most of care within the screening practice and the arrangement of education, tools and support for depression diagnosis and continuous management to assist in systems change. Primary care practices can offer take care of major depressive disorder<sup>(54)</sup>. The Hong Kong and US family medicine studies recommend that this can consist of care of maternal depression<sup>(26,29)</sup>. Referral to mental health experts will continue to be required for the most intricate patients and those who do not react to primary care treatment. In both of the successful programs the referral rate to psychiatrists was 6% of screen favorable females<sup>(26,29)</sup>. Nevertheless, with the around the world scarcity of mental health experts<sup>(21)</sup> it is important that these resources be utilized for intricate cases which efforts are made to incorporate psychological health into primary care<sup>(22,26,29)</sup>. While some combination might imply bringing psychological health professionals into medical care offices, an option may be to supply psychological health services by the individuals already within the practice, the medical care physician supported by the primary care group<sup>(22,26,29)</sup>. The GP role is much clearer when extreme mental illness, such as serious depression, mania or psychosis, occurs as GPs have the tendency to be the primary gatekeepers for new referrals to secondary psychological health services. Early symptoms of manic or psychotic health problem can develop acutely in the postpartum days, with rapid escalation, and should be considered as a real psychiatric emergency situation. Delayed treatment can lead to risk to the safety of mom and infant and longer, more serious, and difficult-to-treat episodes<sup>(21,22,26)</sup>.

#### 4. CONSLUSION

The evidence we consisted of in this analysis targeted mainly postpartum women depression management and diagnosis in medical care and the functions of family doctor in management of PPD. The little proof found concerning pregnant females suggested equivalent effects with postpartum ladies for advantages of screening, accuracy of the EPDS, the indirect evidence revealed that screening instruments can identify pregnant and postpartum ladies who require additional evaluation and may require treatment. Evidence suggested that evaluating pregnant and postpartum females for depression may minimize depressive symptoms in women with depression and lower the prevalence of depression in an offered population.

#### 5. RECOMMENDATION

Depression at this critical period of life carries special meanings and risks to the woman and her family, thus we recommend early screening for this condition, and since the family physicians are the first visited among other doctors, screening programs for PPD should be implemented in primary care. Also this study recommend that family physicians in primary care should go through evaluation procedures to increase their awareness of diagnosis and management of PPD, and not to confuse PPD with differential diagnosis. However, due to the lack of similar studies in middle east, we suggest for more studies should be performed in to evaluate the possible screening management approaches in primary care in Saudi Arabia.

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