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A Study to find Relationship Between Identified Depressive Cases with Causative Factor Among Postnatal Mother

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Abstract: Depression in postpartum is a high prevalence psychiatric illness that is weakening. This thesis aimed at examining the preceding reports. We have stated that studies examining postpartum depression risks by searching the database, Scopus, PubMed, ScienceDirect, Update and Proquest, published in 2000-2015 papers on postpartum depression factors in Farsi and English have been reviewed. A mixture of keywords included postpartum depression and risk factors or obstetric history, social and biological factors. Search strategy The literature review indicated that postpartum depression risk factors were observed in the field of economic and social factors, obstetric and biologic history, mental illness style and history. Data can be used in this study to develop a screening method for women with a high risk and to develop preventive programmes.

Keywords: Narrative review, postpartum depression, risk factors.

1. INTRODUCTION

The strength of the feel of inability to feel among motherly pain is so strong that some postpartum mothers are commenting life as death swamp [2] and undepressed mothers see birth as their happiest stage in their lives.[3] This disease appears as sleep disorder and a mental disorder is a deteriorating mental disorder with a prevalence of about 5% to 60.8% worldwide. The creation of screening systems and the design of preventive programmes on the basis of evidence, however, involves the compilation of scientific records. In the assessment, however there are systematic reviews of some available research that evaluated the services required in order for therapeutic effects of selective serotonin recovery inhibitors to be considerable for post-partum depression [11] and cognitive behavioral treatments [12]. This research was therefore intended to determine risk factors during and after pregnancy for postpartum depression.

A. Social help and risk factors for marital ties

Another factor closely linked to an increased risk of antenatal anxiety and depression is lack of social support. Social support is a multidimensional term, which involves knowledge (information and advice), practical support, and emotional support (evaluation and support). The objective measurement of social support can be difficult because depressed women appear to feel less supported than they are objectively (Robertson et al., 2004).

A significant number of studies report that lack of relationship support and social support are important risk factors in the field of antenatal anxiety and depression. A research conducted in Canada with immigrants (Zelkowitz et al., 2004) has shown women with 12 or more EPDS ideals to be less happy and needier than social assistance. In their networks, they had fewer women, fewer family members and fewer people from their own ethnic group.

Figure 1 Postnatal mother

Help and spousal satisfaction are considered protective factors from antenatal anxiety and depression (Lee et al., 2007, Zeng and al., 2015), whereas a problem, dispute, or unfulfilled/poor relationship with partners has been reported as risk factors in anxiety and depression onset during pregnancy. Strong instrumental and emotional support is important to the child in the future, given mainly by the partner, but also by the family and the social environment. The involvement of a supportive partner serves as a shield to protect maternal mental health from the pressures of adjustment to parenthood (Bilszta et al. 2008). A issue with the spouses instead makes it harder for the woman to adapt to pregnancy and her maternity (Marchesi et al. 2009). (Marchesi et al., 2009).

Other factors, such as marital status or relationship length, may also affect the support received by a new mother and may be considered risk factors for anxiety and depression during pregnancy. Some studies indicate that depressed women with antenatal symptoms may not be married and alone or have spouses with non-residents. A research found that women living with friends or in a group had a higher degree of depression compared to those living with a partner (Balestrieri et al., 2012). However, some researchers (Bilszta et al., 2008) found that there has been a pattern of earlier depression, current emotional issues, previous misuse, levels of everyday disruptions, maternal knowledge of the child and income levels to show evidence that single moms report higher levels of depression during pregnancy than women with supportive partners. Single mothers have, surprisingly, fewer than women with intolerable partners with depressive symptoms (Bilszta et al., 2008). Similarly, a few studies found no substantial forecaster of antenatal depression and anxiety). These results underline the value of considering the nature of a partnership not just as regards marital status. Given these findings, we can conclude that being one mother is better than having a complicated and intolerable bond.

Surprisingly, no findings were reported in this systemic analysis of the partner's psychopathology as a possible risk factor for antenatal depression and anxiety. The potential effect of partner psychopathology has been examined in the first postpartum year on maternal depressive symptoms (D'Anna-Hernandez et al. 2013). There have been no clinical findings linked to the antenatal period. A meta-analytic (Paulson and Bazemore, 2010), but no causal path was found in the studies included in the meta-analytic study which found that the association between maternal or paternal depression was positive and modest in the perinatal period (from the first trimester until the 1st year of a baby).

B. Economic and socio-demographic threats

There are numerous studies exploring socio-demographic and economic risk factors for antenatal anxiety and depression, but the findings are uncertain. Many studies have found a significant correlation between young age and depression/anxiety during pregnancy. This supports what was observed during pregnancy in a systemic study of puberty and mental health (Siegel and Brandon, 2014). Nevertheless, some studies found that an older age was positively associated with depression scores during pregnancy and other studies found that age was not associated with depression or anxiety during pregnancy.

Antenatal depression and anxiety also tend to be more prevalent in low-educated men and women found the reverse association of antenatal anxiety with "alphabeticity." Nevertheless, two studies in Malawi and Pakistan have found that women with more years of education" are more vulnerable to anxiety and depression symptoms. In some studies, the predictor of antenatal depression did not appear in education to be significant.

In addition, there have been more common antenatal anxiety and depression in unemployed women compared with working female workers, compared to employed male and female housewives. It investigated the role of job adversity during pregnancy in maternal well-being. It found that poor working conditions are associated with higher levels of depression in terms of discrimination and lack of main rights during pregnancy. In addition, women whose spouses have been unemployed tend to suffer from antenatal depression more likely.

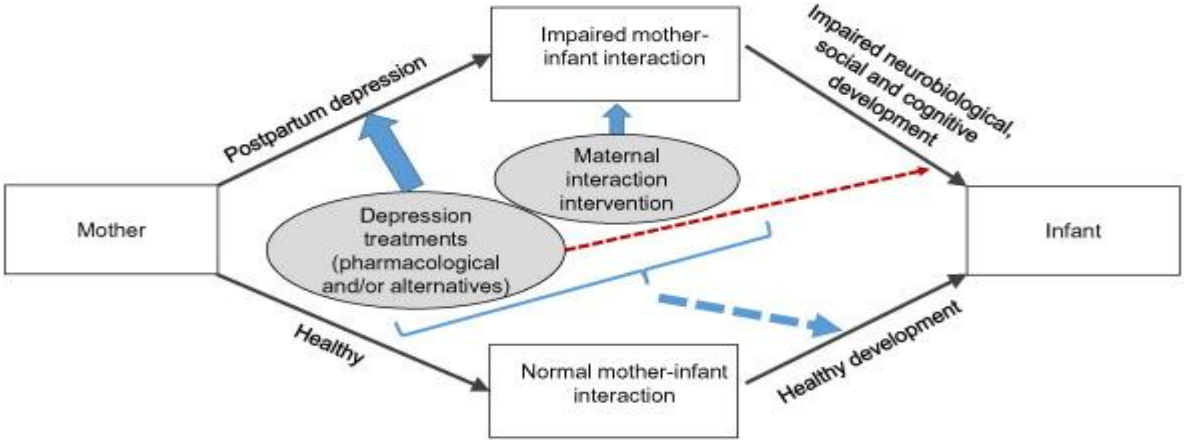

Fig 2. Phases

Studies investigating the correlation of low wages and financial problems have produced conflicting findings as well. While a number of studies were found to have been low-income or financial difficulties in the past.

Ethnicity and most especially, belonging to an ethnic minority group, are additional risk factors that some studies have stressed, even if the findings are conflicting. Antenatal depression is more common in black, latin and asian mothers than in white mothers, although there is not much disparity between them. The risk factor in antenatal depression may be membership of a minority group due to the increased degree of stress induced by prejudice (Prady et al., 2013). Research in the UK has shown, however, that some of the minority groups may experience lower levels of mental illness than the majority (Edge, 2007). Specifically, this research showed no higher depression levels during pregnancy and postpartum, and no longer received perinatal depression treatment than White British mothers, in spite of their membership in a minority ethnic group living in more deprived regions and having a greater probability of becoming lonely mothers, and less support from their husbands. Social risk factors could have different effects on Black and White women's mental health because prolonged and frequent exposure to adversity may have given women in the Black Caribbean more strength and capacity to handle mental distress. The higher levels of capital in Black mothers (social support, spirituality and self-appreciation) can explain this as well as in White mothers (Jesse et al. 2005). These resources will act as an anti-risk buffer and reduce depression incidence. The minority ethnic group may therefore not be an independent factor in relationships with depressive symptoms, and a greater prevalence of other risk factors may contribute to a considerable risk in minority ethnic groups reported in some studies. For that reason, a survey found that lower income and financial difficulty mainly explained the higher prevaleence of depression among Black and Hispanic mothers (Rich-Edwards et al., 2006). In other research, financial issues were correlated substantially with pregnancy mental health problems rather than with membership of a particular ethnic group (Prady et al., 2013).

C. Unfavorable events in life and depression

Many studies have shown that adverse events in life and high perceived stress during pregnancy play an important role in the onset of antenatal depression. Stress experience can vary from mild to harsh, depending on the understanding of stress and the ability to cope. Nonetheless, high-stress situations like death or disease of the relative can cause depressing symptoms or illnesses in most people, break up relationships, lose a career, move home, be attacked or raped. Pregnancy is an agreed period of stress due to the many apparent and possible difficulties. Growing the possibility of mothers or paths developing psychological problems or mental illness will then result in one or more traumatic events. For this reason, a study emphasised the important role of social support in mitigating the negative effects of traumatic events in life: they found women experiencing stressful events but having strong social support are less likely, compared to women who do not have available support network, to experience emotional distress. Therefore, social help will mediate the effects of adverse events in life on

maternal mental health. The theory of "stress buffering" is maintained by endorsing human experiences against the adverse health effects of life events. Nonetheless, the influence of partner abuse on the mental health of women during pregnancy was not mitigated in one study.

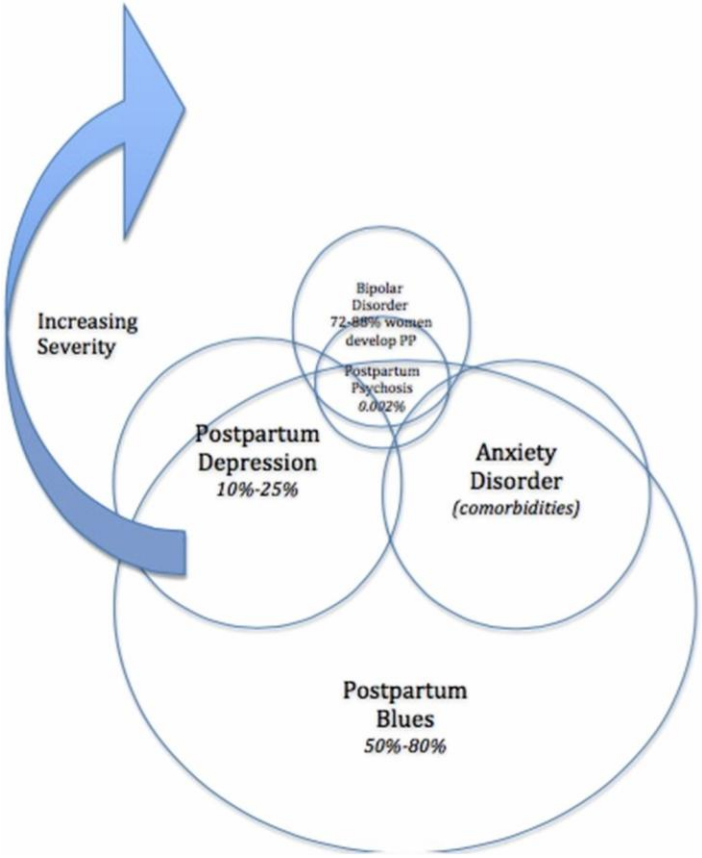

Fig. 2 Depression observed

During life adverse events, it has a profound influence upon a mother's mental health during the perinatal period and is subjected to intrusive life events such as family violence, or social, physical or sexual assault. A number of studies have found that having been exposed to domestic violence before or during pregnancy (particularly if perpetrated by the partner), having a history of abuse, or having experienced a sexual assault, are all risk factors for the development of antenatal anxiety, depression and post-traumatic stress symptoms.

A research showed, in particular, that antenatal anxiety but not depression was associated with traumatic sexual experience (Martini et al., 2015). Another research found that the levels of depressing symptoms of women who are subject to physical attack or sexual coercion during pregnancy by their intimate partners are higher (Martin et al., 2006).

In the literature we know that people with an abuse history often undergo over one lifetime more trauma and have higher levels of depressive and post-traumatic symptoms than women with a single trauma. Indeed, a report identified a substantial rise in depressive scores when both infancy and adulthood are adverse. This correlates to the hypothesis that the build-up of adversity is more harmful than individual incidents. Women sexually abused as children are also

at greater risk of crime, including domestic violence, as a result of adults. In fact, childhood abuse is especially significantly predicted in anti-natal cases of depression and anxiety, with sexual abuse women with childhood history double the risk of having an anti-natal abuse Furthermore, also in the light of anta-social features of mothers, personal history of psychological disorder outside of pregnancy and availability of help for spouses during pregnancy, the association between childhood violence and antenatal depression remains real, which are all recognized as important factors linked to motherly psychopathology.

2. FACTORS LINKED TO OBSTETRICS AND PREGNANCY

Many of the studies showed that women with unexpected or unwanted pregnancy are at increased risk of antenatal depression and anxiety. The unwanted pregnancy was found to be a strong indicator of depression in the first trimester only, which was less relevant over time. Some researchers (Lee et al., 2007) indicated that women initially find it harder to deal with an unwanted and undesired occurrence. As the pregnancy progresses, however the shock decreases and the bond with the foetus improves, the pregnancy increases and the symptoms of depression are decreased. It should also be noted that a greater risk of antenatal anxiety and depression are correlated with fear of birth and depressive thinking on the forthcoming delivery and that a negative pregnancy experiences have been associated substantially with antenatal depression (Agostini et al. 2015).

They have not found an increased number of pregnancies (multigravida) which have been identified as the predictor of antenatal depression. Women with antenatal anxiety were more likely to encounter in one study, but no study was found in other study (Rubertsson et al. 2003). (Bayrampour et al.).

An sudden loss of pregnancy may be devastating and lead to anxiety and depression in subsequent pregnancies. An earlier error has been found to be linked with antenatal depression but there has been no substantial correlation with stillbirth (Rubertsson et al., 2003). An interplay of at least six months for women to recover physically and emotionally appears to play a critical role whether or not a pregnancy that does not lead to a live birth or new pregnancy is anxious and depressing (WHO 2005), according to the World Health Organisation. In order to accomplish this, Gong et al. found that during the first quarter of pregnancy women with a historical abortion and an interval of less than six months are at higher risk for anxiety and depression.

3. RISK FACTORS FOR PERSONALITY

In addition, even after regulating interpersonal influences, motherhood behaviours remain closely connected with anxiety and depression. Such examples of maladaptive maternity values are it's wrong to have my baby's mixed emotions; I need to be more committed to my baby; it's wrong to feel disenchanted with maternity; if my baby is crying out, people think I'm unable to care about it. As a result, women with an ill-adaptive motherhood risk feeling of distress, shame and helplessness, and experience anxiety and depression during and after pregnancy if the

behaviours and perceptions of their feelings do not correlate. This means that some motherhood values can be triggered more strongly with specific parenting stressors.

Selection of studies and extraction of data

The original studies carried out in India in the cross-cutting context of a few weeks to a 1 year after the birth were required in order to be integrated in the systemical analysis. Study carried out in a particular population, such as mothers with a human immunodeficiency virus, including mothers with all existing chronic diseases was omitted. We only considered research conducted in 2000 and later in order to estimate the burden of postpartum depression quite recently. We analysed the complete text of qualifying publications after initial screening of titles and abstracts. Discussions among reviewers resolved decisions about inclusion of studies and interpretation of results. Data were extracted and tabled from all studies which complied with the inclusion criteria.

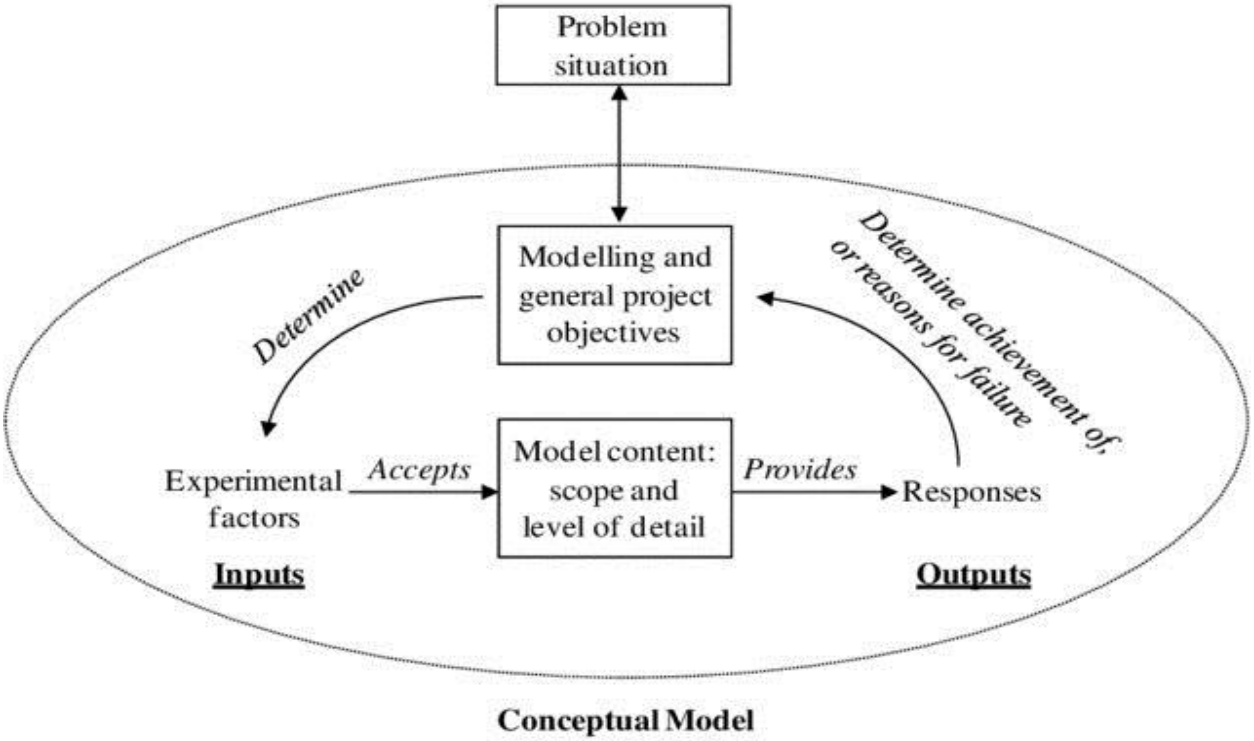

Fig. 4 Conceptual Model

A. Quality evaluation of the analysis

The category of comparability investigates if subjects in the various groups of findings are equivalent based on research design and interpretation and whether or not confounding variables have been regulated. The result group includes whether results data were obtained by an objective blind evaluation, documents or self-reports. The outcome group involves also the clarity and appropriateness of the statistical measures used to evaluate the results. The studies included were evaluated separately by two authors (RPU and KS). A third author (AP) was consulted in the event of inconsistency. We also merged analysis with consistency values in the 5th and 5th grades.

4. ANALYSIS OF DATA

In the included research, we have done a meta-analyzed the recorded postpartum depression prevalence. The statistics of I2 quantified the heterogeneity between studies. The degree of heterogeneity among the studies was strong (> 95 percent) and therefore we used the randoms effect model to derive the clustered estimate for postpartum depression in mothers. We consider that I2-values > 50% represented significant heterogeneity16. The final prevalence figures were seen as 95 percent CI percentages.

We have carried out a subgroup study excluding papers in which a 2 weeks postpartum depression was measured, 1,17,18, as some investigators claim that a 2-week post-partum blues distinction from post-partum depression is difficult. In addition, the postnatal Edinburgh depression scale used in the majority of studies found in the early postpartum will produce false positive results.

We estimated the average age of the study participants using this information. We measured publishing variations by the Egger test and graphically depicted a funnel plot. Lastly, we identified the postpartum depression risk factors.

5. CONCLUSION

Biaological and social influences create interconnected rings that by influencing each other, make women more likely to become postpartum depressed. In this research, the occurrence or prevention of postpartum depression is affected by direct and indirect influence of Serotonin levels and function, as shown by a broad variety of biological and environmental influences, such as lifestyle-based factors. Postpartum depression prevention programmes must also concentrate on the interpersonal interactions of people, reducing domestic violence and increasing social security, in addition to improving the lifestyle of women and increasing their capacity to face the crisis. Based on the findings, in addition to physical conditions of individuals, the methods for the post-partum depression predictor should also be focused on social factors and lifestyles.

6. REFERENCES

[1]. J. Wang, Q. Yun, S. F. Ma, H. R. Song, M. N. Guo, and W. N. Zhang, “Inhibition of expression of glucocorticoids receptors may contribute to postpartum depression,” Biochem. Biophys. Res. Commun., vol. 523, no. 1, pp. 159–164, 2020, doi: 10.1016/j.bbrc.2019.12.040.

[2]. A. Haim, C. Albin-Brooks, M. Sherer, E. Mills, and B. Leuner, “The effects of gestational stress and Selective Serotonin reuptake inhibitor antidepressant treatment on structural plasticity in the postpartum brain - A translational model for postpartum depression,” Horm. Behav., vol. 77, pp. 124–131, 2016, doi: 10.1016/j.yhbeh.2015.05.005.

[3]. S. Brummelte and L. A. M. Galea, “Postpartum depression: Etiology, treatment and consequences for maternal care,” Horm. Behav., vol. 77, pp. 153–166, 2016, doi: 10.1016/j.yhbeh.2015.08.008.

[4]. N. McRae et al., "Blood manganese levels during pregnancy and postpartum depression: A cohort study among women in Mexico," Neurotoxicology, vol. 76, no. June 2019, pp. 183–190, 2020, doi: 10.1016/j.neuro.2019.11.005.

[5]. E. Comasco, M. Gulinello, C. Hellgren, A. Skalkidou, S. Sylven, and I. Sundström-Poromaa, "Sleep duration, depression, and oxytocinergic genotype influence prepulse inhibition of the startle reflex in postpartum women," Eur. Neuropsychopharmacol., vol. 26, no. 4, pp. 767–776, 2016, doi: 10.1016/j.euroneuro.2016.01.002.

[6]. A. Bjertrup et al., "Cognitive processing of infant stimuli in pregnant women with and without affective disorders and the association to postpartum depression," Bipolar Disord., vol. 22, pp. 110–111, 2020, doi: 10.1016/j.euroneuro.2020.10.006.

[7]. Y. Jin, J. Coad, R. Pond, N. Kim, and L. Brough, "Selenium intake and status of postpartum women and postnatal depression during the first year after childbirth in New Zealand – Mother and Infant Nutrition Investigation (MINI) study," J. Trace Elem. Med. Biol., vol. 61, no. March, p. 126503, 2020, doi: 10.1016/j.jtemb.2020.126503.

[8]. S. R. De Vriese, A. B. Christophe, and M. Maes, "Lowered serum n-3 polyunsaturated fatty acid (PUFA) levels predict the occurrence of postpartum depression: Further evidence that lowered n-PUFAs are related to major depression," Life Sci., vol. 73, no. 25, pp. 3181–3187, 2003, doi: 10.1016/j.lfs.2003.02.001.

[9]. A. R. Gobinath et al., "Voluntary running influences the efficacy of fluoxetine in a model of postpartum depression," Neuropharmacology, vol. 128, pp. 106–118, 2018, doi: 10.1016/j.neuropharm.2017.09.017.

[10]. W. Qiu, P. Duarte-Guterman, R. S. Eid, K. A. Go, Y. Lamers, and L. A. M. Galea, "Postpartum fluoxetine increased maternal inflammatory signalling and decreased tryptophan metabolism: Clues for efficacy," Neuropharmacology, vol. 175, no. February, 2020, doi: 10.1016/j.neuropharm.2020.108174.

[11]. A. Overgaard, S. E. Lieblich, R. Richardson, L. A. M. Galea, and V. G. Frokjaer, "Paroxetine blunts the corticosterone response to swim-induced stress and increases depressive-like behavior in a rat model of postpartum depression," Psychoneuroendocrinology, vol. 89, no. October 2017, pp. 223–228, 2018, doi: 10.1016/j.psyneuen.2017.10.021.

[12]. A. D. Green, A. M. Barr, and L. A. M. Galea, "Role of estradiol withdrawal in 'anhedonic' sucrose consumption: A model of postpartum depression," Physiol. Behav., vol. 97, no. 2, pp. 259–265, 2009, doi: 10.1016/j.physbeh.2009.02.020.

[13]. C. E. Schiller, M. W. O'Hara, D. R. Rubinow, and A. K. Johnson, "Estradiol modulates anhedonia and behavioral despair in rats and negative affect in a subgroup of women at high risk for postpartum depression," Physiol. Behav., vol. 119, pp. 137–144, 2013, doi: 10.1016/j.physbeh.2013.06.009.

[14]. K. Czarzasta et al., "A rat model to study maternal depression during pregnancy and postpartum periods, its comorbidity with cardiovascular diseases and

neurodevelopmental impact in the offspring," Physiol. Behav., vol. 199, no. May 2018, pp. 258–264, 2019, doi: 10.1016/j.physbeh.2018.11.024.

[15]. J. L. Payne and J. Maguire, "Pathophysiological mechanisms implicated in postpartum depression," Front. Neuroendocrinol., vol. 52, no. December 2018, pp. 165–180, 2019, doi: 10.1016/j.yfrne.2018.12.001.

[16]. N. P. Deems and B. Leuner, "Pregnancy, postpartum and parity: Resilience and vulnerability in brain health and disease," Front. Neuroendocrinol., vol. 57, no. July 2019, p. 100820, 2020, doi: 10.1016/j.yfrne.2020.100820.

[17]. M. Rincón-Cortés and A. A. Grace, "Adaptations in reward-related behaviors and mesolimbic dopamine function during motherhood and the postpartum period," Front. Neuroendocrinol., vol. 57, no. March, p. 100839, 2020, doi: 10.1016/j.yfrne.2020.100839.

[18]. W. Qiu, T. E. Hodges, E. L. Clark, S. A. Blankers, and L. A. M. Galea, "Perinatal depression: Heterogeneity of disease and in animal models," Front. Neuroendocrinol., vol. 59, no. May, p. 100854, 2020, doi: 10.1016/j.yfrne.2020.100854.

[19]. L. M. Glynn, E. P. Davis, and C. A. Sandman, "New insights into the role of perinatal HPA-axis dysregulation in postpartum depression," Neuropeptides, vol. 47, no. 6, pp. 363–370, 2013, doi: 10.1016/j.npep.2013.10.007.

[20]. A. F. Jarman, J. V. MacLean, R. J. Barron, R. S. Wightman, and A. J. McGregor, "Brexanolone For Postpartum Depression: A Novel Approach and a Call for Comprehensive Postpartum Care," Clin. Ther., vol. 42, no. 1, pp. 231–235, 2020, doi: 10.1016/j.clinthera.2019.11.005.

[21]. M. Azami, G. Badfar, A. Soleymani, and S. Rahmati, "The association between gestational diabetes and postpartum depression: A systematic review and meta-analysis," Diabetes Res. Clin. Pract., vol. 149, pp. 147–155, 2019, doi: 10.1016/j.diabres.2019.01.034.

[22]. D. Y. Quansah, J. Gross, L. Gilbert, A. Arhab, A. Horsch, and J. J. Puder, "Predictors and consequences of weight retention in the early and late postpartum period in women with gestational diabetes," Diabetes Res. Clin. Pract., vol. 165, p. 108238, 2020, doi: 10.1016/j.diabres.2020.108238.

[23]. K. M. Yount and S. M. Smith, "Gender and postpartum depression in Arab Middle Eastern women," Womens. Stud. Int. Forum, vol. 35, no. 4, pp. 187–193, 2012, doi: 10.1016/j.wsif.2012.03.017.

[24]. S. Brummelte and L. A. M. Galea, "Depression during pregnancy and postpartum: Contribution of stress and ovarian hormones," Prog. Neuro-Psychopharmacology Biol. Psychiatry, vol. 34, no. 5, pp. 766–776, 2010, doi: 10.1016/j.pnpbp.2009.09.006.

[25]. J. W. Fernandez, J. A. Grizzell, and L. Wecker, "The role of estrogen receptor β and nicotinic cholinergic receptors in postpartum depression," Prog. Neuro-Psychopharmacology Biol. Psychiatry, vol. 40, no. 1, pp. 199–206, 2013, doi: 10.1016/j.pnpbp.2012.10.002.