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Postpartum Affective Disorders

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Abstract. Pregnancy, chilbirth and postpartum is time of transition for a women and complex life event can accure on biological, psicological and social experienced by mother. Physical and emotional changes led to a prospective mother need adaptation. If the mother does not succeed so that mothers can suffer psychological disorders with different symptoms or syndromes. This article aims to assess postpartum affective disorder in the postpartum period. Postpartum affective disorders are typically divided into three categories: postpartum blues, postpartum depression dan puerperal (postpartum) psychosis differentiated by prevalence, onset, and duration. Postpartum blues is the most common with estimated prevalence ranging from 30 to 75%, onset within a few days after childbirt. prevalence postpartum depression 10-15%. Postpartum depression usually begins within the first 6 week following delivery and psychosis postpartum uncomon with prevalence ranging from 0,1 to 0,2%. And the clinical onset is rapid, with symtoms presenting as early as the first 48-72 h postpartum. Factor affecting postpartum affective disorders including anxiety during pregnancy, depression during pregnancy, live event, social support, neuroticism, socioeconomic status and obstetric factors. The impact of postpartum affective disorders on the mother related with morbidity and mortality and can develop into major depressive disorder can event become postpartum psychosis. While the impact on the baby influence mental development, dan and the babys motoric, cognitive and emotional development. Threatment can be given on postpartum affective disorders in accordance with the diagnosis. In the postpartum blues no treament required other than reassurance. Management on postpartum depression treatment usually required by health proffesional, exercise, therapy antidepressant, while on postpartum psychosis hospitalization usually required.

INTRODUCTION

Pregnancy and childbirth is a dynamic event throughout life and affect women physically and psychologically. In the first week of delivery is a time of great emotional changes occur. After delivery,a change in the role of being a mother, and a change in the marital relationship and also in families [1]. The first month after birth is a critical period in mothers with psychiatric symptoms and is associated with postpartum depression. Psychiatric disorders may complicate the postpartum period both of which appear in the postpartum period or recurrence of previous symptoms. Postpartum affective disorder causes of mortality and morbidity. Patients with postpartum affective disorder and some have to do treatment in hospital. Postpartum affective disorders include postpartum blues, postpartum depression and postpartum psychosis. This affective disorder diagnosed during the postpartum period, symptoms and treatment is not generally differ with care in women during the cycle of its life cycle [2]. postpartum affective disorders fall into three categories: postpartum blues, postpartum depression and postpartum psychosis [3].

Recent study reported that risk factors associated with postpartum disorders, among others primigravida, unwanted pregnancy, childbirth with sectiocaesarea or complications in infants, a history of psychiatric disorders, stress in life and no social supportof [4]. Mothers with a history of mood disorders, bipolar disorder is a risk factor occurs postpartum affective disorder [5].

Base on the category of postpartum mood disorder, that postpartum blues or baby blues is a feeling of the most common disorder with an estimated prevalence of 30% -75% [6]. Postpartum blues is a mild syndrome typically experienced by women with the first week to ten days after delivery [6]. Factors related to the incidence of early postpartum blues is the support of family [1].

Another category of postpartum affective disorder is postpartum depression. Prevalence of postpartum depression 10-15% [7]. In Asian the prevalence of postpartum depression between 3.5% to 63.3% [8].The cause of postpartum depression is not just one cause but from the physical and emotional factors.Postpartum affective

disorder is rare postpartum psychosis with the incidence of 1-2 per 1000 births [3]. Postpartum mood disorders will affect quality of life, and an inability to meet the everyday needs such as in terms of employment, spouse and mother. In infants will have an impact on cognitive and emotional [9].

DISCUSSION

Postpartum Blues

Postpartum blues or *baby blues* is the most common observed puerperal mood disturbance. Postpartum blues is a transitory phenomenon of mood changes that begins within the first few day after delivery and can last 1 to 10 days or longer [10]. Prevalence postpartum blues ranging from 30% - 75 % [6]. Onset of postpartum blues 3 or 4 days after delivery [3, 2]. postpartum blues occur in the first week to ten days of birth.

Symptoms of postpartum blues can include dysphoria, mood lability, crying, anxiety, insomnia, poor appetite and iritability. O'hara *et al* (1991) cit Pariser *at al* [2] in their study found that women with postpartum blues were more likely to develop postpartum depression than women who did not experience postpartum blues. O'Hara *et al* also found that women who met criteria for poatpartum blues were moer likely to have been depressed before pregnancy to have had premenstrual depressionfound that women who have a history of postpartum blues allowed to occur postpartum depression and women who have risk factors for postpartum depression blues allowing pregnancy and postpartum depression

Predictors of the postpartum blues in O'Hara *et al* (1991) cit Pariser *et al* [2] included personal and family history of major depression, stressful life events and lack of social support. According to recent study Takahasi dan Takamosi [1] concucted alongitudinal study of women who had normal deliveries during 4-5 day hospitalization and at a health check-up 1 month after delivery assessed using Maternity Blues Scale (MBS) and Edinburgh Posnatal Depression Scale (EPDS) reported that the same relationship to the MBS and EPDS scores that need its support to reduce the risk of postpartum blues and depression.

Management of postpartum blues no treatment required other than reassurance. Active treatment is not required in addition to the provision of support [5] in this case the support provided can be instrumental support, emotional support, informational support and the support award [11].

Postpartum Depression

Depression was a period of disturbance in the function associated with the natural human feeling sad and accompanying symptoms, including changes in sleep patterns, psychomotor, concentration, anhedonia, fatigue, despair and helplessness and suicidal disorder [12]. Depression is a mood disorder or affective feeling atmosphere [13]. Postpartum Depression is an emotional state characterised by episodes of crying and feeling sad light moment during the first 10 days after birth [14]. The incidence of postpartum depression occurs in approximately 10-15% of new mothers [7]. In Asian countries the prevalence of postpartum depression between 3.5% to 63.3% [8].

A etiology the cause of postpartum depression is not just one cause but from the physical and emotional factors. During pregnancy, until labouroccurs hormonal changes, during childbirth, decreased levels of estrogen and progesterone are very fast and the increase of the hormone prolactin is the aetiology of postpartum affective disorder, resulting in changes in the brain system and make changes in mood in the mother [15].

Postpartum depression has a significant negative impact on cognitive, social and development of children. Baby in mothers with depression will experience cognitive delays, psychology, neurology and motor development [16, 17]. Postpartum depression also causes effects on the social and personal lives of new mothers, such as the effects of maternal and infant relationship and marriage relationship [18] and also the interest and the interest of the baby less and less able to care for her baby optimally, including breastfeeding.

Some risk factors that can lead to postpartum depression based on the literature review [10, 3, 15] are as follows:

a. History of depression

Literature review with a sample of more than 3700 studies found that a history of depression has a strong relationship strength 0,58. Besides the previous study also mentioned that a person who has a family with the psychiatric disease will be associated with depression with weak ties [3].

b. Anxiety or depression in pregnancy

Recent study with more than 1100 respondents that mothers who have experienced depression or anxiety during pregnancy had a significant relationship to the occurrence of postpartum depression [3]. The high score of anxiety during pregnancy is a risk factor and Symptoms from postpartum depression. depression during pregnancy has a strong relationship to the incidence of postpartum depression [10].

c. Social support

Is the force that will affect individual concepts, attitudes and behavior [11]. Much of the research related to social support and postpartum depression. lack of social support is risk factors for the development of postpartum depression [19]. Literatur review conducted by Stewart *et al* [15] with a sample of more than 3500 found that social support has a strong correlation with the incidence of postpartum depression.

literatur review revealed that women who experience postpartum depression feel that the limited support of their husbands, being unable to understand the changes that occur in mothers postpartum when compared endorsement by friends or family, especially women, where there is a relationship of mutual trust [20]). A description of the effects of health support on health described by Gottilieb (1983) in Nursalam [21]described in the two theories, namely the buffer hypothesis and direct effect hypothesis.

Theory buffer hypothesis revealed that social support will affect a person's health by protecting against the negative effects of stress by protecting individuals against the negative effects arising from the pressures he endured. This hypothesis function when a person experiences stress strong pressure. High social support will change the individual response to the sources of stress by sharing stories with others who are considered to provide social support. While in theory hypothesis effect of high and low-stress intensities comparable with positive social support.The higher the social support received by individuals, increasingly have the confidence that makes individuals are not vulnerable to stress.

To assess social support on postpartum mothers there are several questionnaires that can be used one Social Support Questionnaire (SSQ) developed by Sarason et al [11]. SSQ describe reflexes affective aspects of the relationship or degree of feeling, help, the trust received by someone. The instrument consists of 27 items of questions and each question there are two answers to a) answer who provide social support and points b) answer how satisfied respondents support against the support given. The answer to point a) there are 9 options for filling the source of social support come from anyone and obtained from each of the questions and also replenish items satisfaction the support received, whereas for the answer points b) comprises 6 Likert scales to assess the satisfaction that has given by source of support. Satisfaction scores for each item are very satisfied (SP) = 6 Satisfied (P) = 5, Somewhat Satisfied (AP) = 4, Somewhat Dissatisfieds

d. Life event

Cause a person experiences stress differently each individual. Happenings in life can increase stress as losing someone loved, losing a job, moving house, a good relationship with the couple would trigger depression in someone who has no previous history of depression. For some people, pregnancy and childbirth are caused stress and depression in life. stress or incident in the life of the factor that causes postpartum depression [3]. Stress can be a change in the marital relationship, a job change performance economic crisis, hospitalisation for during the period of pregnancy and childbirth and postpartum is a factor the causes of postpartum depression [10].

e. Socio-economic status

Socio-economic status includes income, education and employment. The Socioeconomic status associated with the incidence of postpartum depression, the lower the family income of more incidence risk of postpartum depression [6]. A study on postpartum mothers with Arab nationality and Qatar gets the result that income has a significant relationship with postpartum depression with OR: 1.78 and CI: 1.19 to 2.67 [18].

Work is all the work done or done to get salary assessed with money. There is a significant correlation in women with postpartum depression incidence with OR: 1.78; CI: 1.19-2.67, the risk of postpartum depression increased 2-fold in women who do not work than mothers who work, it is because mothers who take care of children at home only to experience a state of crisis situations and disturbances due to fatigue and feeling tired they feel [18].

f. Obstetric factors

Obstetric factors including 1) unplaned or aunwanted pregnancy 2) pregnancy related complication such as preeclampsia, hyperemesis, premature labor, 3) nor bresfeeding, 4) delivery-related complication , such as caesarean section, intrumental delivery, as research conducted by Irawati (2014) has been reported that there is no significant relationship mode of delivery to the incidence of postpartum blues, but in women who experience post SC higher postpartum blues. Other studies mention that in labour SC EPDS score higher when compared with normal delivery, but there was not significant difference [22].

Signs and symptoms of depression do not all experience the same symptoms. The severity, frequency and duration vary depending on the individual and specific diseases. Signs and symptoms are sadness, anxiety and feeling empty, feelings of hopelessness or pessimism, feelings of guilt, worthlessness and helplessness, loss of interest in activities or daily activities including sex, difficulty concentrating or making decisions almost every day, sleep disorders (insomnia, hypersomnia), changes in appetite (with increase or decrease in body weight), thoughts of suicide, attempted suicide, pain or tenderness, headaches, cramps, or digestive problems, lack of energy or fatigue nearly every day.

Postpartum depression has serious consequences for the subsequent life of the mother, which, if not handled properly depression will develop into psychosis. Postpartum depression affects baby's development, among other things some of the impacts on cognitive development. Mothers who experience depression will significantly impact on mental and motor development of infants at the age of 1 year and there is also an emotional disturbance and cognitive development in infants whose mothers experience postpartum depression [9]. Husain *et al* [23] found that there are significant differences between infants in mothers with depression on behavior.

Screening to detect a mood disorder/depression is a reference to a routine postnatal care abroad. To do this screening can be used tools such as the Edinburgh Postnatal Depression Scale (EPDS) developed by Cox [24] is a questionnaire with a validity tested to measure the intensity of depressive mood swings during the seven days after the copy. The questions relate to the feelings lability, anxiety, feelings of guilt and matters contained in the postpartum blues. This questionnaire consists of 10 questions in which each question has four possible answers and have to choose one according to the gradation of feeling felt by the mother after the current copy. Questions to be answered by the patient and the average completed within 5 minutes. This tool has proven its validity in some countries such as the Netherlands, Sweden, Australia, and Indonesia. EPDS can be used within the first week after the copy if the dubious results can be repeated again 2 weeks later [25].

Cox [24] recommended the cut-off score of 12/13 for detecting postpartum major depression with a value of 86% sensitivity, 78% specificity and positive reductio p-value 73%, with the value of the error rate reported between 14-16%. Another advantage of the EPDS is: simple, quickly done (takes 5-10 minutes) to complete the questionnaire EPDS, easily calculated (by nurses, midwives and other health workers), early detection of postpartum depression, not cost, more acceptable by patients.

Psikosis Postpartum

Postpartum psychosis is the most severe an uncommon form of posnatal affective illness, with rates of 1-2 episodes per 1000 deliveries. [3]. The clinical onset is rapid, with symptoms presenting as early as the first 48-72 hour postpartum, with the majority of episodes developing within the first 2 weeks after parturition [3]. The presenting symtoms are typically depressed or elated mood, disorganized behavioral, mood lability, and delusions and hallucinations.

Risk factors of postpartum psychosis is a history of a previous pregnancy psychosis, bipolar disorder history, family history of psychotic disorders [4]). Postpartum psychosis is almost not diagnosed but can be used for early detection routine during postpartum visits and questionnaires using the EPDS questionnaire mood disorders and physical exercise during the postpartum necessary to reduce the risk of postpartum depression [26]. Postpartum mothers experience postpartum depression are at increased risk of postpartum depression decreased by 50% after a given intervention gymnastics parturition.

Management of postpartum psychosis need treatment by a specialist in psychiatry and pharmacology treatment is necessary. Mothers with postpartum psychosis will occur 50% of mental disorders in other periods during its life cycle [5]).

CONCLUSSION

Postpartum affective disorderdivided into 3 postpartum blues, postpartum depression and postpartum psychosis. The cause of the postpartum affective disorder is a history of the previous affective disorder, a family with a history of psychiatric illness. The need for early detection of all current postpartum maternal postpartum visits with the psychological examination, not only the physical examination.

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