



GESTATIONAL DEPRESSION, ANXIETY AND ITS MANAGEMENT

Clinical Science

Dr Manal I Shaikh* Consultant Psychiatrist, Dharwad.*Corresponding Author

Dr Dashleen Kaur First Year Junior Resident, Department Of Psychiatry, D Y Patil, Kolhapur

Dr Safiya Shaikh DNB Consultant, Dept Of Anaesthesia, Civil Hospital, Dharwad

ABSTRACT

Ubiquity of psychiatry disorders, particularly affective and anxiety ailment are seen in women in their child bearing years.¹ Although the prevalence of affective disorders are high, pregnant women who are diagnosed are far less and women who actually get treated are even fewer. This discrepancy can be attributed to various factors such as overlapping of symptoms commonly seen in pregnancy and affective disorders. Even when diagnosed with psychiatry ailments there is hesitancy seen among these women to start medication for fear of harming foetus due to psychotropics. Hesitancy is also seen among medical professionals due to lack of properly formulated guidelines for treatment of pregnant women with psychiatry ailment. In this article we have tried to review and summarise about causes, symptoms and guidelines for treatment of anxiety and affective ailments in pregnancy.

KEYWORDS

Gestation, pregnancy, depression ,anxiety

INTRODUCTION

Pregnancy and motherhood can essentially be described as cardinal part of womanhood and very essence of the existence. Along with immense joy and pleasure that accompany pregnancy, women also face many challenges. Psychiatry disorders, particularly affective and anxiety ailment have highest occurrence amongst women in their child bearing years.¹

Even though plenty of pregnant women are symptomatic, women who are diagnosed are far less. This could be due to overlapping of symptoms commonly seen in pregnancy and affective disorders. Another factor is the tendency of pregnant women as well as health care worker to focus on physical wellbeing of women but ignoring the mental health aspect. Symptoms of psychiatric illness such as disturbed sleep and appetite, reduced amount of energy, decreased interest level may be incorrectly assumed to be symptoms associated with normal physiological and psychological changes in pregnancy.²

Women who are diagnosed may choose not to take treatment with fear of adverse effects the psychotropics may have on foetus. This article aims at reviewing various factors involved in leading to affective disorders as well as treatment strategies.

PREVALENCE

- During pregnancy around 7.5% women suffer from a new episode of major depression.³
- During first 3 months after delivery 6.5% develop a new episode of depression.⁴
- If we take into account both major and minor depression, it increases the prevalence further to 14.5%, both antenatal period and initial 3 months of postnatal period.⁵
- Postpartum depression is prevalent between 7% to 30% of women.⁶

CAUSES OF PERINATAL DEPRESSION AND ANXIETY

• Hormonal problems

Due to the meticulous composition of the female endocrine system and interaction of the hypothalamo-pituitary and hypothalamo-gonadal axis, it is likely that ovarian hormone level variations lead to heightened susceptibility to stress and lead to sad affect in women.⁷

In the postpartum phase, striking hormonal alterations take place. Later period of normal gestation is related to elevation in levels of oestrogen and progesterone with high plasma cortisol. Peptides linked to gestation, such as oxytocin, dampen HPA axis reactivity. In contrast to non reproductive period the cortisol measures are higher during gestation. In pregnancy it is also seen that, the normal diurnal pattern of cortisol is either flattened or inconsistent. During pregnancy baseline levels of ACTH are also greater than before, on other hand its sensitivity or feedback inhibition appears down regulated.^{7,8}

• Iron deficiency

A research done in gestational women found that during the middle

of pregnancy or towards the term, there is a link between iron deficiency and antenatal depression. Indicating that iron deficiency may perhaps play significant role for developing sad mood during gestation.⁹

• Social support

Another precursor for sad mood is the lack of reinforcement socially. There is a much greater correlation of postnatal social support and post partum depression than prenatal social support. The data also shows that lack of social reinforcement causes significant damage, and external risk element such as smoking will markedly intensify its effects.¹⁰

• Unplanned pregnancy

Postpartum depression was strongly associated with accidental gestation and infant characteristics. Women whose newborn babies were sick were more prone to feel down, sad, lethargic. Concern about the baby's health and capability to deal with an unhealthy or sick child's treatment could be responsible for this.¹¹

• Problems with spouse

It was proposed in a research work that difficult alliance with the spouse speaks to an extra pressure, which diminishes the chance of women handling pregnancy and affirms the information of past investigations that showed that conjugal fulfilment is protective factor against melancholy during gestation. Brutality against ladies, a significant general wellbeing worry in a nation in which more than 33% of women report being beaten by their spouses is a noteworthy element contributing for perinatal affective symptoms.¹²

• Previous episode of MDD

Females who already have suffered from an episode of major depression are more prone to a return of depressive episode during gestation due to biologic and psychological causes.¹³

• Sex of baby

The inclination for male kids is profoundly established in Indian culture; such sex predisposition and the restricted control a lady has over her reproductive wellbeing may make pregnancy a distressing encounter for certain ladies.¹³

• Less favorable socio-demographics

Females with less schooling are probably going to be affected more by antenatal sad mood and stress related ailments.¹⁴ Unemployed women and housewives have been discovered to have more pervasive gestational anxiety and depression. It established that working conditions, like bias or favouritism and need of help for child bearing women are related with more elevated levels of depressive and anxiety ailment. Besides, gravid women whose spouse were jobless are bound to encounter antenatal depression more often.¹⁵

• Protective factor

In many previous studies it is already established that satisfaction in

marital life and apparent social reinforcement are preventive elements against antenatal anxiety and depression. Many investigations have put forward that ladies who experience unpleasant life situations yet have great social help are less inclined to experience the ill effects contrasted to the females without an accessible supportive group. Hence it is to be concluded that the repercussions of stressors on psychological health of women can be modified by the character of reinforcement she is receiving socially.¹⁶

CINICAL PRESENTATION

Women often present with atypical manifestation of affective disorder and vague somatic complaints. They can present with symptoms such as exhaustion, reduced amount energy, changes in hunger and sleep, rather than low mood. Hence it becomes quite challenging to diagnose depression and anxiety devoid of an actual standardised assessment.

The DSM-5 time-specifier stops at 1-month postpartum to denote a condition with the most biological connection to hormonal shifts of gestation and delivery. In primiparous mothers, a 2- to 3-fold increased rate of PPD that was fairly spread over the initial 5 months of postpartum.

The most widespread mental illnesses are anxiety disorders. Women have a higher average lifetime risk of anxiety disorders in contrast with men. Hence it becomes important that gynaecologists and primary care practitioners to be familiar with the anxiety disorders to promote early discovery and management.²

Outcomes of affective disorders and anxiety during pregnancy on mother and child A biological consequence of excessive stress in pregnancy is rise of the glucocorticoids in gravid women and the baby. Various outcomes that are seen due to stress during gestation are preterm delivery, prematurity, and decreased birth weight in the new born baby. Identifying these mothers who are suffering from affective or anxiety disorder during gestation is of prime importance as they can potentially predict depression during postpartum period.

Rates of anxiety co morbidity in female with perinatal depression reach 50 percent. Medical diagnoses such as hypo/hyperthyroidism, anaemia, and hypertension have a similar phenotype and ought to be ruled out.⁷

TREATMENT

Many pregnant women who are diagnosed with the mental ailments often face the dilemma, whether to start medications, fearing the adverse effects of the medications on the foetus. This leads to grossly under treated mental illness in pregnancy. This is due to the fact that the information available for patients as well as health care workers is limited.

Research on Psychiatric Treatments in pregnant women by the American Psychiatric Association has come up with well formulated step wise decision making protocol to help psychiatrist come up with proper management modality. Many experienced clinicians and researchers are of opinion that affective ailments, if long term in duration or is of moderate to severe intensity, somatic interventions should be endorsed.

According to this model formulated by American Psychiatric association first step is coming to a diagnosis, and informing the patient about the natural course of the illness and possible ill effects on mother as well as baby.

Treatment strategy needs to be personalised in each case depending upon severity, doctor's opinion and preference of the patient.¹⁷

• Psychotherapy

According to the guidelines given by American Psychiatric Association and the American College of Obstetrics and Gynaecology, psychotherapy should be preferred in pregnant women who are suffering from mild to moderate depression. Although effective and many studies have proved its benefits, it does have few cons. The relief seen with psychotherapy is gradual, is time consuming and has to be conducted through multiple sessions and has a steep price. Amongst psychotherapy Interpersonal psychotherapy has been adapted and used successfully for treating pregnant patients with depression. Certain alternatives to conventional interpersonal psychotherapy like brief Interpersonal Psychotherapy are being devised and used and also have been found to be effective.¹⁷

• Pharmacotherapy

Antidepressants are very efficacious and cost effective treatment, especially in pregnant women with moderate to severe depression. There are certain concerns regarding effects of the medications may have on foetus. American Psychiatric Association assessed these under these five domains (intrauterine foetal death, physical malformations, growth impairment, behavioural teratogenicity, and neonatal toxicity) Tricyclic antidepressants, fluoxetine or newer Selective Serotonin Reuptake Inhibitors (SSRI) have not shown any evidence of intrauterine death after their usage in pregnancy.

Data from various studies also did not find any major morphological teratogenicity with tricyclic antidepressants, fluoxetine or newer SSRI. Although there is a single study which showed 3 or more minor physical anomalies in infants exposed to fluoxetine.¹⁸

Growth impairment was not seen in infants of pregnant women who were taking tricyclic antidepressant and newer SSRIs. Although it was seen that with exposure of fluoxetine for around 5 to 6 months infants born were of lower birth weight, which has been attributable lower maternal weight gain. Hence if a psychiatrist is thinking of starting Fluoxetine in pregnant women it is advisable to monitor weight of women.

Behavioural teratogenicity in terms of cognitive functions, temperament or general behaviour was not found in infants exposed to tricyclic antidepressant and SSRI. A neonatal withdrawal syndrome, with symptoms of transient jerky movements and seizures, tachypnea, tachycardia, irritability, feeding difficulties and profuse sweating were seen in infants. A clinical action which can be implemented to reduce the withdrawal symptoms tapering any drug dose prior to delivery to minimise the foetal load at birth. Tapering should be done with careful consideration as early dose tapering may lead to recurrent depression in pregnant women.¹⁸

• Electroconvulsive therapy

It has been time and again shown in various studies and by clinical experts alike that ECT is safe in pregnancy. Only adverse effects experienced by foetus is premature contraction and preterm labour but it occurs very rarely and in those cases ECT has not been clearly proved to be the cause. ECT has also not been associated with anomalies, congenital or behavioural or neurocognitive impairment.¹⁹

CONCLUSION

There have been many advances in this field and this research work needs to be converted into clinical practice for the benefit of pregnant women. Certain well formulated treatment strategies may serve as bridge to gap between research work and practical implications. Management strategy for each patient needs to be personalised based on severity of disease and even considering the preferences of pregnant women.

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