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Research Article

THE BABY SYMPTOM: THE POSTPARTUM DEPRESSION

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A B S T R A C T

Postpartum depression is a pretty severe depression occurring between six weeks and one year after childbirth. Its prevalence is estimated between 10 and 20% with an average of 13%. Several factors are involved in the genesis of these depressive states, including genetic, hormonal, neurobiological and psychosocial environment. The clinical picture is highly polymorphic, dominated by anxiety, emotional numbing, irritability and somatization, centered on the baby who may be the only symptom of maternal depression. The postpartum depression has a negative impact on early mother-child relationship as well as the further development of the child. Their screening using the Edinburgh Postnatal Depression Scale (EPDS), thus appears primordial and appealed to all healthcare professionals: pediatrician, obstetrician, gynecologist, midwife. We report the case of a patient with a late diagnosed postpartum depression to illustrate the complexity of the clinical picture and the value of early screening.

INTRODUCTION

The postpartum constitutes is a period of vulnerability peculiar to the decompensations of psychiatric disorders. Postpartum depression is a fairly severe depressive state occurring between six weeks and one year postpartum, its prevalence is estimated to be between 10 and 20% with an average of 13% [1], it is the disorder of the most common mood in the perinatal period.

The clinical picture is very polymorphic, dominated by anxiety, emotional blunting, irritability and somatization, centered on the baby, which may be the only symptom of maternal depression. Indeed, depressed mothers react badly to the child's signals; there is a negative correlation between depressive symptoms and maternal sensitivity.

The diagnosis and treatment of postpartum depression is a public mental health problem because of its consequences for the family and the child [2], so it is necessary to detect and prevent these conditions to mitigate the pathogenic effects as soon as possible.

Observation

The patient is 26 years old, without a psychiatric history, mother of a 9-month-old infant, referred by the pediatrician for an anxiety state.

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For the past six months she has been attending pediatric consultations regularly, bringing her baby for various reasons despite the reassurance.

The patient's clinical presentation included strong anxiety centered on her baby, feeling tired, crying, and irritability. Clinical evaluation using the Edinburgh Postnatal Scale confirmed the diagnosis of postpartum depression which was developing for 5 months. Mood sadness and anxiety were adjusted through antidepressant therapy and psychotherapeutic support.

DISCUSSION

The expression of symptoms of postpartum depression varies along a continuum from simple fatigue or irritability to the inability to care for the baby. These clinical forms were initially synthesized by Pitt in 1968 in his main article "Abnormal Postpartum Depression" [3].

The onset is often insidious after variable duration latency, sometimes in the form of long-term postpartum depression [4]. Two frequency peaks were reported: about the sixth week, then between the ninth and fifteenth month after birth.

The classic picture of psychological slowdown and suicidal thinking will be rare. Postpartum depression manifests itself primarily in silent suffering that combines anxiety, irritability, hidden crying, feelings of exhaustion, feelings of inability to meet the needs of the child and emotional commitment, loss of libido and fear motivation that can dominate the image.

One of the semi-topical characteristics of postpartum depression is the ability to appear directly through the relationship with the infant; Not suitable for baby. In fact, depressed mothers find it difficult to understand and answer the child's signals correctly. Finally, despite the low suicide rate in these depressive situations [5], the disappearance of the feeling that the child is useful should alert the professional immediately. Postpartum depression has negative consequences for the early mother-child relationship, as well as for the subsequent growth of the child [6]. Therefore, it seems necessary to detect and prevent these conditions in order to mitigate the pathogenic effects as soon as possible.

The Edinburgh Postpartum Depression Scale (EPDS), has been used since 1987, as a specific and accurate indicator for screening and positive diagnosis of pregnancy and postpartum depression [4]. It is a subjective questionnaire, consisting of ten elements, each classified from 0 to 3, in an increasing order of intensity, so the total score in EPDS ranges from 0 to 30. Several factors overlap the genesis of postpartum depression, including the genetic, hormonal, neurological and psychosocial environment. Hypotheses are imposed to explain the characteristics of these depressive conditions and many neurobiological mechanisms with therapeutic effects under study.

The history of depression and the presence of anxious or depressive manifestations during the prenatal period are the most important [7]. Prematurity and low birth weight increases the prevalence of postpartum depression up to 40%. Obstetric complications appear to be a minor risk factor [8]. Other risk factors were studied: postpartum anemia [9], low level of social support and low socioeconomic status, young age and smoking [7].

The interaction between genes and the environment in postpartum depression has been well defined in many studies [10], and a low level of docosahexenoic acid (DHA) [11] and vitamin D [12], has been associated with an increase in depression symptoms in postpartum women. Breastfeeding appears to be a protective factor against postpartum depression by reducing total retinal concentrations that accumulate in the prenatal period and remain elevated after birth [13].

CONCLUSION

The case presented indicates the variation of clinical representation, the frequency of somatization and the clandestine nature of postpartum depression. Diagnosis is difficult because most mothers who do not know their condition are not consulted.

The examination, using the Edinburgh Postpartum Depression Scale (EPDS), is therefore necessary; appeals to all health professionals: pediatrician, obstetrician/gynecologist and midwife. Early psychological care adapted to the psychosocial model improves diagnosis and reduces the estimated recurrence of depression by 25% [14].

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