

Impact of Postpartum Depression on Male Infants: A Preliminary Literary Review

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Abstract

Background: Postpartum Depression is also known as Postnatal Depression. It is the mood disorder and constitutes borderline between Baby Blues and Postpartum Psychosis, the two other affective disorders. Emotional lability, hopelessness, guiltiness, tearfulness, anorexia, insomnia, low energy, anhedonia, suicidal ideation, infanticide tendency as well as feelings of being incapable to cope with the fatigue, poor concentration cum memory and infant irritability characterize Postpartum Depression (PPD).

Objective: The current study endeavors to reveal the impact of Postpartum Depression (PPD) on male infants particularly up to 18 months of age.

Methodology: The present study is based on systematic and impartial analysis of available literature. Google Scholar, Research Gate, Pub Med, Wikipedia and books are used as data bases.

Interpretation: Postpartum Depression (PPD) besides affecting the new mother, her marital relationship, and her children, affects physically, mentally and emotionally her newborn particularly male infant, the most. If left untreated it can have adverse long-term effects on mother-infant relationship and infant growth and development. Research testimonies to the fact are early cessation of breastfeeding, infant underweight, short for age, little or no love for infant, infant irritability, insecure attachment between mother and infant, Sudden Infant Death Syndrome (SIDS), et cetera.

Conclusion: It is to conclude from the present review studies that Postpartum Depression (PPD) has harmful impact on the physical, mental, emotional and behavioral development of infants, particularly of males. The impact of severe and lingering depression episode is likely to be worse. Early relevant clinical and social intervention is therefore need of an hour.

Suggestion: Postpartum Depression (PPD) is often unrecognized and undertreated which adds to the prevalence of and morbidity caused by the disorder especially in Asian countries. The reason for it is similarity of clinical manifestations in the Postnatal Depression to Major Depression (MD) occurring at other times in women. Obstetrics and Pediatrics should play their role in early diagnosis, and in psychiatrist referral of the affected mothers in addition to educating the masses especially mothers and particularly teen age mothers about etiological factors and symptoms of Postpartum Depression (PPD) as well as about associated risks related to both mother and infant to help prevent and reduce the infant morbidity caused by the disorder.

Keywords: *Postpartum Depression (PPD), Impact, Infants, Male.*

Introduction

Postpartum means after childbirth or after delivery (John W. Santrock, 1996). Postpartum period is prone to development of serious mood disorders. The association of mood disturbances with postpartum period has been noted since Hippocrates time (Miller, 2002). There is more risk for woman to be admitted to a psychiatric hospital within the first month of postpartum (Kendell et al, 1987; Paffenbarger, 1982).

Generally, Postpartum Depression (PPD) refers to the emotional distress experienced by women after childbirth (Mary Gloria C. Njoku, 2013). Strictly, it refers to non-psychotic depressive episode that begins in the postpartum period (Cox et al., 1993; O'Hara, 1994; Watson et al, 1984).

Postpartum Depression (PPD) is a serious psychological illness. It begins within the first six weeks of postpartum as usual and most cases require treatment by health specialists. However 10 to 16% of women affected begin to experience symptoms of the disorder during pregnancy. The disorder is most obvious after 4 - 6 months of delivery. It affects 13-15% of women population in general (Donna E. Stewart et al, 2003). However the prevalence of the disorder in adolescent mothers is reported to be as high as 26% (Troutman & Cutrona, 1990).

Interactions of genetic and environmental factors cause Postpartum Depression (PPD) (Dubovsky & Buzan, 1999).

The disorder starts as Baby Blues and then gets worse over time. The illness primarily affects the brain, hence behavior of the mother thereby tells upon her ability to perform daily chores for herself as well as for her infant and others.

Emotional lability, hopelessness, guiltiness, tearfulness, anorexia, insomnia, low energy, anhedonia, suicidal ideation, infanticide tendency as well as feelings of being incapable to cope with the fatigue, poor concentration cum memory and infant irritability characterize Postpartum Depression (PPD). Some women see themselves as bad/inadequate/unloving

mothers due to their excessive worry about the baby's health or feeding habits (Robinson et al., 2001).

Pronounced effects of Postpartum Depression (PPD) on the diseased mother, on her marital relationship and on her infant makes prevention, diagnosis, treatment and follow up of the illness mandatory (Robinson & Stewart, 2001; Milap Kumar Patel et al., 2012).

There are different prevention, diagnostic and treatment interventions of the disorder. Whilst more severe Postpartum Depression (PPD) is easily detected, the less severe presentation of depressive disease is easily dismissed as normal or natural consequences of parturition. The reason for it is similarity of clinical manifestation of depression occurring in the Postnatal Depression to Major Depression (MD) occurring at other times in women (Nonacs & Cohen, 1998).

In absence of treatment Postnatal Depression can last for more than three months even for years, hence can profoundly tell upon the quality of life of the diseased woman as well as have adverse effects on her infant. For the mother, the lengthy episode of Postpartum Depression (PPD) can be the precursor of Recurrent Chronic Depression. For her children, underway Postpartum Depression (PPD) contributes to physical in addition to cognitive, affective, behavioral and interpersonal problems in later life (Jacobsen, 1999).

Depression, anxiety, experience of stressful life events and poor social support during pregnancy (Donna E. Stewart et al., 2003), obstetric complications and high levels of childcare stress, low self esteem, neuroticism, infant temperament, depressed mood (O'Hara and Swain (1996), insomnia and appetite disturbance, low energy and diminished libido (Nonacs & Cohen, 1998) after pregnancy are key predictors of postpartum depression.

Review of the Literature

Robinson & Stewart (2001)¹³ hold that effects of Postpartum Depression (PPD) on the mother, her marital relationship, and her children make it essential condition to prevent, diagnose and treat.

Jacobsen (1999)² believes that untreated Postpartum Depression (PPD) can have adverse long-term effects. For the mother, the lengthy episode of Postpartum Depression (PPD) can be the precursor of Recurrent Chronic Depression. For her children, underway Postpartum Depression (PPD) contributes to physical in addition to cognitive, affective, behavioral and interpersonal problems in later life.

John W. Santrock (1996)¹⁴ writes that long lasting emotional fluctuations (due to sex hormones imbalance (Wisner et al, 2002) and fatigue) in the postpartum period produce feelings of depression. Consequently infant is to bear the brunt of indifferent attitude of her mother, primarily.

Warner R., Appleby, L., Whitton, A., & Faragher, B. (1996)¹⁸ reveal in the study that postpartum non-psychotic depression is the most common complication of childbearing. It approximately affects 10-15% of women and as such represents a considerable public health problem affecting women and their families.

Objective of the Study

To study the impact of Postpartum Depression (PPD) on male infants particularly up to 18 months of age with reference to physical, mental, emotional and behavioral development.

Methodology

Systematic and objective content analysis approach is adopted in the present study to study the consequences of Postpartum Depression (PPD) on male infants.

Discussion

It is to elucidate from systematic and objective analysis of the available literature that Postpartum Depression (PPD) has significant and selective repercussions on the physical, mental, emotional and behavioral development of the infant. Arguments to justify the fact follow. Postpartum Depression (PPD) is considerably associated with being underweight at six months and with being short for age (Patel, 2003). Infants of Postpartum Depression (PPD) mothers perform appreciably less well on cognitive tasks at 18 months than children of non Postpartum Depression (PPD) mothers, particularly the males (Bayley, 1969; Murray, 1992; Beck, 1998). Postpartum Depression (PPD) causes insecure attachments between mothers and babies due to breakdown in harmony/attunement between mother and baby (Tronick & Weinberg, 1997). Postpartum Depression (PPD) is the cause of early cessation of breast feeding and frequent use of compensatory feeding by mothers (Cooper et al, 1993). Infants of depressed mothers show more negative and less positive expressions than their counterparts of non-depressed mothers, in general. However, Postpartum Depression (PPD) affects temperament of 6 months infants, in particular (Sugawara, Kitamura, Toda, & Shima, 1999). The relationship between Postpartum Depression (PPD) and latency as well as intensity of crying in infants is significant. Infants of Postpartum Depression (PPD) mothers are quicker to cry in response to stimuli and their crying is louder and longer (Jones, 2001). Postpartum Depression (PPD) may add to distractibility, neurotic/antisocial behavior and effect choice of child play especially in males. Postpartum Depression (PPD) may be a risk factor for Sudden Infant Death Syndrome (SIDS) (Sanderson et al, 2002). Postpartum Depression (PPD) is one of the leading causes of infanticide of infants of less than one year of age (M. G. Spinelli, 2004).

Conclusion

It is to conclude from the present review studies that Postpartum Depression (PPD) has harmful impact on the physical, mental, emotional and behavioral development of male infants. The impact of the severe and lingering depression episode is likely to be worse. Early relevant clinical and social intervention is therefore need of an hour.

Suggestions

Postpartum Depression (PPD) is often unrecognized and undertreated which adds to the prevalence of and morbidity caused by the disorder in infants. The reason for it is similarity of clinical manifestations in the Postnatal Depression to Major Depression (MD) occurring at other times in women. Obstetrics and Pediatrics should play their role in early diagnosis, and in psychiatrist referral of the affected mothers in addition to educating the masses especially mothers and particularly teen age mothers about etiological factors and symptoms of Postpartum Depression (PPD) as well as about associated risks related to both mother and infant to help prevent and reduce the infant morbidity caused by the disorder.

Postpartum Depression (PPD) largely affects the Asian Countries and particularly the adolescent mothers. The Continent and the group of women therefore require more attention to curtail the prevalence and morbidity caused by the disorder.

Women having previous history of depression or family history of psychiatric illness also require special attention to reduce infant morbidity caused by the disorder.

Unplanned or unwanted pregnancy should be discouraged to prevent development of Postpartum Depression (PPD), hence harmful impact on infants.

The use of standardized tools for assessment of Postpartum Depression (PPD) in all cultural groups is not suitable due to cultural differences. Therefore the professionals need to be culturally sensitive in various interventions related to the disorder.

The minimal studies support impact of Postpartum Depression (PPD) on infants. Therefore further research in this area is suggested to understand in detail the relationship between Postpartum Depression (PPD) and infant morbidity.

The strongest study on long-term effects of Postpartum Depression (PPD) on infants also needs to be undertaken.

Out of the station Postpartum Depression (PPD) experience also requires fine attention. Under such circumstances affected women may be at higher risk due to dearth of social support, cultural expectations of motherhood and unwillingness to unveil the symptoms and to receive care from the health specialists.

Provision of social support during stressful time of pregnancy should be there. It is thought to be a protective factor against developing Postpartum Depression (PPD).

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References

- [1]. Beck, C. T. (1998). *The effects of postpartum depression on child development: a meta-analysis*. Archives of Psychiatric Nursing, 12, 12-20.
- [2]. Jacobsen, T. (1999). *Effects of postpartum disorders on parenting and on offspring*. In L. J. Miller (Ed.), *Postpartum Mood Disorders* (pp. 119-139). Washington, D.C: American Psychiatric Press.
- [3]. Kendell, R. E., Chalmers, J. C., & Platz, C. (1987). *Epidemiology of puerperal psychoses*. Br. J Psychiatry, 150, 662-673.
- [4]. Mayberry, L. J. & Affonso, D. D. (1993). *Infant temperament and postpartum depression: a review*. Health Care for Women International, 14, 201-211.
- [5]. Miller, L. J. (2002). *Postpartum depression*. JAMA, 287, 762-765.
- [6]. Murray, L. (1992). *The impact of postnatal depression on infant development*. Journal of Child Psychology and Psychiatry and Allied Disciplines, 33, 543-561.
- [7]. Njoku, C. G. M. (2013). *Causes and consequences of postpartum depression among women*. The International Journal of Social Sciences, 15(1), 64-69.
- [8]. Nonacs, R. & Cohen, L. S. (1998). *Postpartum mood disorders: diagnosis and treatment guidelines*. Journal of Clinical Psychiatry, 59 Suppl 2, 34-40.
- [9]. O'Hara, M. W. (1994). *Postpartum depression: Causes and Consequences*. New York: Springer-Verlag.
- [10]. Paffenbarger, R. S. (1982). *Epidemiological aspects of mental illness associated with childbearing*. In I.F. Brockington & R. Kumar (Eds.), *Motherhood and Mental Illness*. London: Academic Press.
- [11]. Patel, V., DeSouza, N., & Rodrigues, M. (2003). *Postnatal depression and infant growth and development in low income countries: a cohort study from Goa, India*. Archives of Disease in Childhood, 88, 34-37.
- [12]. Patel, M. et al (2012). *Postpartum Depression: A Review*. Journal of Health Care for the Poor and Underserved, Volume 23, Number 2, May 2012, pp. 534-542.
- [13]. Robinson, G. E. & Stewart, D. E. (2001). *Postpartum disorders*. In N.L. Stotland & D. E. Stewart (Eds.), *Psychological aspects of women's health care* (2nd ed. ed., pp. 117-139). Washington, DC: American Psychiatric Press, Inc.
- [14]. Santrock, J. W. (1996). *Child Development*. USA, Brown and Benchmark Publishers, 129.
- [15]. Spinelli, M. G. (2004). *Maternal infanticide associated with mental illness: prevention and the promise of saved lives*. The American Journal of Psychiatry, 161 (9): 1548-57
- [16]. Stein, A., Gath, D. H., Bucher, J., Bond, A., Day, A., & Cooper, P. J. (1991). *The relationship between postnatal depression and mother-child interaction*. British Journal of Psychiatry, 158, 46-52.

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- [17]. Troutman, B. R. & Cutrona, C. E. (1990). *Nonpsychotic postpartum depression among adolescent mothers*. Journal of Abnormal Psychology, 99, 69-78.
- [18]. Warner, R., Appleby, L., Whitton, A., & Faragher, B. (1996). *Demographic and obstetric risk factors for postnatal psychiatric morbidity*. British Journal of Psychiatry, 168, 607-611.
- [19]. Watson, J. P., Elliott, S. A., Rugg, A. J., & Brough, D. I. (1984). *Psychiatric disorder in pregnancy and the first postnatal year*. British Journal of Psychiatry, 144, 453-462. Weich