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Review Paper

Review On Postpartum Anxiety and Depression

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ABSTRACT

Postpartum depression and anxiety are among the most common mental health issues affecting women in the first year following childbirth. During this time, there are significant changes in hormones, which can have serious health implications for new mothers. If not addressed, these mental health issues can have serious implications for the child's development and the family. This review is intended to offer a comprehensive account of postpartum depression and anxiety. It will cover issues such as the prevalence of these mental health issues, the causes of these problems, the symptoms of these problems, and how these problems can be managed. According to global research, 10-20% of women are at risk of developing postpartum depression. Similarly, 25% of women suffer from anxiety disorders following childbirth. The causes of these problems can be attributed to a sudden decline in the levels of estrogen and progesterone hormones following delivery. These hormones control essential neurotransmitters in the brain. Other causes of these problems include a history of mental illness, lack of social support, poor marital relationships, financial problems, and complications during pregnancy. Early detection is essential for the proper management of these conditions. The Edinburgh Postnatal Depression Scale, Patient Health Questionnaire-9, and Generalised Anxiety Disorder-7 are some of the tools used for detection. The management of these conditions includes a combination of psychotherapeutic and pharmacological interventions, lifestyle changes, and social support. Cognitive behavioural therapy and interpersonal therapy have shown promising results for managing these conditions. Health care providers such as nurses and family doctors play an important role in promoting the health of mothers by managing these conditions. Preventive strategies such as education of pregnant women, strengthening support systems of the family, and increasing awareness are essential for managing these conditions and reducing their effects.

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INTRODUCTION

The postpartum period is a transformative time for a woman, characterised by profound physiological, hormonal, emotional, and social changes. As the mother recovers from childbirth and adjusts to caring for a newborn, she may experience emotional symptoms like feelings of guilt or hopelessness[1]. Some women also face difficulty concentrating, changes in appetite, or a reduced capacity to care for themselves and their infant [2].

A frequently under-recognised condition during this time is postpartum anxiety disorder. It is marked by excessive worry, restlessness, irritability, and persistent fears about the baby's health and safety. Affected women often feel overwhelmed and struggle to relax or sleep due to constant concern about their infant [3].

Globally, the prevalence of postpartum mental health disorders is high. Research shows that postpartum depression affects 10–20% of mothers, while anxiety symptoms affect up to 20– 25% of women in the postpartum period [4], [5]. A recent cross-sectional study reported rates as high as 12.9% for postpartum depression and 20.8% for postpartum anxiety, highlighting how common these conditions are[6]. In India, a meta-analysis found that 19% of mothers experience postpartum depression, emphasizing the need to prioritize maternal mental health as a public health issue [7].

Untreated postpartum depression and anxiety can have lasting effects. These conditions may interfere with breastfeeding, mother-infant bonding, and the mother's ability to respond to her child's emotional needs [8]. Consequently, children of mothers with untreated postpartum depression may face developmental challenges in emotional, cognitive, and social domains [9].

Given the growing awareness of maternal mental health, proper management of postpartum depression and anxiety is essential. Educating healthcare providers and families can lead to healthier outcomes for both mothers and their children [10].

The impact of untreated mental health issues in the postpartum period is not limited to the mother-child dyad. Rather, it has a significant impact on the family system. For example, partners of mothers suffering from postpartum depression have been found to have high levels of stress, increased levels of caregiving, and even depression. Siblings of the newborn have also been found to have behavioral changes due to the mother's lack of emotional resources. Thus, it is essential to view postpartum mental health from a family perspective. [8], [9].

In spite of the availability of effective tools for screening and treatment modalities, there is still much to be done to address the gaps in the identification and treatment of PPMH. Barriers to the treatment and management of PPMH include low mental health literacy among women and their families, inadequate training among healthcare providers, the lack of coordination among healthcare providers, and the stigma associated with mental health. It is important to address these barriers to the treatment and management of PPMH through a multifaceted approach. [10], [11].

Additionally, recent world events have underscored the importance of maternal mental health in crisis situations. For example, the recent COVID-19 pandemic has resulted in a lack of support systems, reduced face-to-face care, and increased apprehension concerning infant safety and health, thereby leading to an increased prevalence of PPD and PA in various parts of the world. This has, therefore, emphasized the importance of a strong health care system that is able to provide care to mothers in crisis situations and has also led to the innovation of telemental health care to cater to those who might not be

reached within a traditional system [12].

Rationale

The issues of postpartum depression and anxiety are among the most common yet least understood mental health problems in the first year following childbirth. The rationale for the presentation of this in-depth overview is the need for the timely synthesis of current information on these issues in a manner that is not only academically sound but also easily understood by health professionals, the general public, and interested parties.

The postpartum period is a distinct time in a woman's life that is characterized by significant physiological changes. Among these changes are the abrupt drops in estrogen and progesterone levels, disruption of the hypothalamic-pituitary-adrenal axis, and changes in the levels of neurotransmitters that control mood swings. However, these physiological changes have to be understood in the context of psychological factors such as a history of mental health problems or poor coping skills. Moreover, these physiological changes have to be understood in the context of social factors such as inadequate support networks, financial difficulties, and cultural issues. All these changes have to be understood in order to appreciate the development of postpartum mental health problems.

Epidemiological studies show that the prevalence rates for PPD among women lie between 10 to 20%, while PPA affects up to 25% of women. Moreover, in developing countries like India, the rates vary between 15 and 23%. It is evident that these rates are directly related to factors like socioeconomic status, educational level, and access to medical facilities. It is important to note that these rates show the widespread nature of PPD and PPA. It is not an isolated incident; it is a public health issue that needs to be addressed.

The clinical presentation is variable, ranging from feelings of low mood and withdrawal to excessive worrying and thinking. It is important to note that the consequences of these conditions can affect the mother to the extent that she is unable to show affection towards her child. It can affect the child, the family, and the society as well.

Early detection with the help of scientifically validated tools such as the Edinburgh Postnatal Depression Scale and the Patient Health Questionnaire-9 is the key to early intervention. Despite the above, gaps exist in the routine screening process, often due to stigma, lack of education among caregivers, and the fractured healthcare system. Bridging the gaps requires an holistic approach to the integration of mental health with routine maternal-child healthcare.

The management of the condition varies according to the individual's needs, from psychological interventions such as cognitive-behavioural therapy and interpersonal therapy for mild to moderate forms, to pharmacological interventions such as selective serotonin reuptake inhibitors for more severe forms. Supportive care from nurses, who are the primary caregivers during the antenatal and postnatal periods, is indispensable.

Prevention is the best way forward. Antenatal education, building support networks, and creating culturally sensitive awareness campaigns are effective measures to reduce the incidence and severity of the disorders. By empowering the individual, the community, and the population with knowledge, the history of postpartum mental health disorders can be rewritten from one of suffering in silence to one of hope, support, and healing.

Epidemiology of Postpartum Depression and Anxiety

Postpartum depression and anxiety are significant public health concerns during the first year after childbirth. Epidemiology—the study of distribution and determinants—provides crucial insights for developing effective interventions [13].

Globally, the prevalence of postpartum depression ranges from 10% to 20%, though this varies by population and diagnostic methods [14]. Because some symptoms are mistaken for normal postpartum changes, the condition often remains undiagnosed, suggesting the actual prevalence may be higher than reported [10].

Anxiety disorders are also common in the postpartum period, with prevalence rates between 15% and 25% [14]. These include generalized anxiety disorder, panic disorder, obsessivecompulsive symptoms, and health-related anxiety.

A large systematic review estimated the global prevalence of postpartum depression at around 17%, with higher rates in low- and middle-income countries where mental health services and social support are limited [9]. High-income countries generally report lower rates due to better maternal health infrastructure and screening programs. In India, prevalence ranges from 15% to 23%, influenced by socioeconomic status, education, and healthcare access [7], [15].

Key demographic risk factors include young maternal age, low education, financial instability, and unplanned pregnancy [3], [16]. Lack of social support and stressful life events during pregnancy also contribute [17]. The COVID-19 pandemic exacerbated these issues, with studies reporting increased rates of postpartum anxiety and depression due to social isolation, health concerns, and reduced access to care [12].

Epidemiological evidence confirms that postpartum depression and anxiety are widespread, yet often undiagnosed and untreated, underscoring the urgent need for better support systems [11].

The geographic differences in the prevalence of PPD have shown some very significant patterns. In countries such as those in sub-Saharan Africa and South Asia, the prevalence of postpartum depression has been found to be as high as 25% to 30%, due to the cumulative effects of poverty, food scarcity, poor mental health services, and high rates of gender-based violence. On the other hand, in Scandinavian countries, which have some of the most advanced social welfare programs, parental leave policies, and integrated mental health programs for mothers, the prevalence of postpartum depression has been found to be between 5% to 10% in these countries. [9], [11].

Temporal trends in prevalence are also important. Longitudinal studies over several decades have indicated that the prevalence of postpartum depression may be rising in some geographic locations due to changing social patterns and a decrease in support systems of the extended family. Isolation and increasing age of the mother are also thought to play a role. However, it is also possible that better detection and awareness are causing an increase in prevalence, and it is not clear if incidence is rising or if detection is better [11], [14].

The epidemiology of postpartum anxiety has received less research attention than depression, although recent studies are attempting to fill this void. Unlike postpartum depression, which has a peak incidence in the first three months after delivery, anxiety symptoms have a tendency to appear before delivery and last for longer periods of time if left untreated. Panic disorder, in particular, has a unique pattern in its epidemiology, with many women experiencing their first incidence in the perinatal period. Obsessive-compulsive symptoms have a unique pattern in their epidemiology, with a 3% to 12% rate in the postpartum period, with a tendency for intrusive thoughts focused on harming the infant [14], [16].

Some studies also show the existence of seasonal factors, with the rates of PPD being greater during the winter season when the level of sunlight is low. Moreover, the contrast between urban and rural settings is also noteworthy. While the rural setting

is plagued by the difficulties associated with geographic inaccessibility, the urban setting is characterized by different factors, including housing difficulties, longer working hours, and decreased social cohesion [10], [17].

The economic toll of untreated PPD and anxiety is considerable. Studies on the monetary cost of these conditions to society, in terms of healthcare expenditures, productivity loss, and developmental effects on the child, have shown that there is considerable economic benefit to investing in prevention programs. For every dollar invested in screening programs, several dollars can be saved in future healthcare expenditures. The need for the provision of these services is evident [9], [11].

Pathophysiology of Postpartum Depression and Anxiety

The etiology of postpartum depression and anxiety appears to be a complex interaction of biological, psychological, and environmental factors. The postpartum period is characterized by significant fluctuations in hormones, brain chemistry, sleep deprivation, and emotional stress, all of which can contribute to depression and anxiety [18].

One of the most important biological mechanisms is the sharp drop in levels of reproductive hormones after delivery. The levels of estrogen and progesterone are significantly elevated during pregnancy and drop sharply after delivery. The sharp drop in these hormones may influence neurotransmitter activity in the brain, which includes serotonin and dopamine that control mood and emotional stability [4], [19]. Progesterone metabolites function as natural anti-anxiety compounds, and the rapid withdrawal of these metabolites can cause anxiety.

This period also affects the hypothalamic-pituitary-adrenal axis, which is responsible for the regulation of the body's stress response. Cortical hormones, which are high during pregnancy, show rapid changes during the early weeks after delivery, resulting in abnormal stress reactions. [20].

Sleep deprivation is another key factor. New mothers often experience fragmented sleep due to infant care demands, which can impair cognitive function and heighten the risk of depression and anxiety [21]. Additionally, inflammatory processes may play a role; elevated levels of inflammatory cytokines in the postpartum period have been linked to mood disturbances in susceptible women [22].

These psychological and social factors, such as a lack of social support, financial problems, relationship problems, and prior mental health issues, interact with these biological changes to affect postpartum mental health disorders[3], [9].

Apart from these well-established pathways, recent research has helped identify other biological pathways that contribute to postpartum mental health disorders. Genetic susceptibility is one such factor. Women who have certain genetic risk factors, such as those involving serotonin transport, estrogen metabolism, or inflammation, are more susceptible to postpartum depression and anxiety. Family studies have indicated that having a first-degree family member who has had a history of postpartum mental health disorders can increase the risk of a woman experiencing these problems herself. [4], [18].

The role of the gut brain axis has also received increased attention in recent times. The significant changes in dietary habits, sleep, and stress levels in the postpartum period can result in changes in the composition of the gut microbiome in women. Such changes may play a role in influencing mood through the synthesis of neurotransmitters and inflammatory mediators, which can traverse the blood brain barrier. Research has revealed that women with postpartum depression show unique gut microbiome compositions in comparison to healthy women in the postpartum phase, which can

provide a new direction for therapeutic interventions [9], [22].

Thyroid dysfunction is another important biological consideration. The demands of pregnancy place a tremendous burden on the thyroid gland, and postpartum thyroiditis can occur. This condition consists of transient hyperthyroidism and then hypothyroidism. The imbalance of thyroid hormones can have behavioral manifestations that mimic depression and anxiety, including fatigue, mood instability, and cognitive problems. The screening for thyroid dysfunction in women presenting with postpartum mood problems is an important consideration in the comprehensive evaluation. [19], [20].

The neurobiological changes that are associated with motherhood are also relevant. The period of pregnancy and postpartum is associated with considerable neuroplasticity in brain systems that are involved in caregiving behaviors and emotional and stress responses. Although these changes are generally adaptive for mother-baby bonding and responding to the baby's needs, in vulnerable individuals, these changes may also contribute to emotional intensity and difficulty in managing negative emotions. Advances in neuroimaging have shown changes in the connectivity of brain systems involved in emotional processing in postpartum depression in women. [18], [21].

In this regard, the concept of allostatic load, which refers to the consequences of chronic stress and physiological adaptations to environmental demands, is useful in explaining the individual differences in susceptibility. Women who enter the perinatal period with high allostatic load, as a result of past trauma, chronic stress, or adverse life experiences, may not be able to adapt to the demands of new motherhood. This is because the physiological consequences of high allostatic load result in dysregulation in various physiological systems, including the HPA axis, immune system, and neurotransmitters, which contribute to the susceptibility to PPD and anxiety [9], [20].

Clinical Manifestations of Postpartum Depression and Anxiety

The signs of postpartum depression and anxiety may vary but could have a significant effect on the mother and her ability to care for her baby. The symptoms may develop in the first few weeks after delivery but could also appear any time during the first year. [14].

Women with postpartum depression often experience persistent sadness, emptiness, and loss of interest in previously enjoyable activities. These feelings may be accompanied by fatigue, irritability, and difficulty concentrating. Many also struggle with guilt, feeling they are not capable of caring for their child [11]. Sleep disturbances are common; beyond the usual sleep deprivation of new motherhood, affected women may suffer from insomnia or find it difficult to sleep even when the baby is resting [21]. Appetite and weight changes can also occur, along with emotional withdrawal and a lack of bonding with the infant [8]. In severe cases, feelings of hopelessness or thoughts of self-harm may arise, requiring immediate intervention [9].

Postpartum anxiety, meanwhile, is characterized by excessive worry, agitation, and persistent fears about the baby's health—often disproportionate to the actual situation [14]. Physical symptoms can include rapid heartbeat, shortness of breath, dizziness, and an inability to relax. Some mothers experience panic attacks with sudden fear, sweating, and chest pain [3]. Others may have obsessive thoughts about the baby's safety, such as repeatedly checking breathing or experiencing unwanted, distressing thoughts about harm coming to the baby. While these thoughts are recognized as intrusive and unwanted, they can be very distressing [14].

It is worth noting that there is a significant overlap in symptoms of both depression and anxiety in these patients. It is not uncommon for a woman to experience a mixture of both diseases at once; in these cases, the condition is sometimes referred to as comorbid postpartum depression and anxiety. This is particularly difficult as these patients may feel more emotionally distressed due to increased irritability, dread, and a complete sense of overwhelm regarding their daily activities. [3], [9].
Another aspect that needs attention is the cognitive symptoms. Women who suffer from mental health disorders during the postpartum period often complain about memory, decision-making, and attention problems. They feel as though they are not able to do things, or they feel as though they are in a fog all day. These cognitive symptoms make it difficult for the woman to carry out her duties as a mother, go for appointments, or hold meaningful conversations with her loved ones. Some women feel as though they are living on autopilot, as though they are not connected to the world around them, nor connected to who they are as people [8], [21].
In addition to this, the presentation of PPD and PA can differ among different cultures. For example, in some cultures, women with PPD and PA may show their emotional distress through physical symptoms such as headaches, gastrointestinal upsets, and fatigue. It is important to note these different manifestations to ensure that the healthcare providers do not misdiagnose the women with PPD and PA. Furthermore, women with PPD and PA may show manifestations such as anger and rage. These manifestations are not well addressed and can be equally disturbing to family life. [14].
The intensity and period of symptoms may vary over time. While some may have a gradual worsening of symptoms over a period of time, others may have flare-ups of symptoms due to various stressors such as sick infants, sleep deprivation, and relationship problems. The knowledge of such variability again highlights the need for continuous assessment and not just a snapshot of symptoms in the initial postpartum period. [9], [11].

Risk Factors of Postpartum Depression and Anxiety

Postpartum depression and anxiety result from the interaction of multiple biological, psychological, and social factors. Identifying these risk factors is essential for early detection and prevention [3].
A prior history of mental health disorders is one of the strongest predictors. Women with previous depression, anxiety, or other psychiatric conditions are two to three times more likely to develop postpartum depression compared to those without such histories[1], [9]. Hormonal fluctuations after childbirth, particularly the rapid decline in estrogen and progesterone, also play a significant role [4].
Social support is a critical protective factor. Women who lack support from a partner, family, or community are more vulnerable to feeling overwhelmed and psychologically exhausted [18]. Marital conflict and poor communication with a partner further increase risk [16]. Socioeconomic factors such as financial stress, unemployment, and low educational attainment are also linked to higher rates of postpartum depression and anxiety [7].
Pregnancy-related variables such as unwanted pregnancy, complications during gestation, and preterm birth may also cause emotional distress. Problems in breastfeeding and childcare may cause frustration and low self-esteem. Sleep deprivation is also a problem in the early postpartum period, which negatively influences emotional control and stress resistance capabilities. [21].
Demographic factors such as younger age, teenage pregnancy, and first-time motherhood are

associated with increased risk due to limited experience and heightened uncertainty [17]. Exposure to traumatic events—such as domestic violence, loss of a loved one, or major life stressors during pregnancy—can also heighten vulnerability [3].

Personality characteristics and coping styles are further risk factors. Women who are perfectionists, who lack self-esteem, or who tend to ruminate on negative thoughts are possibly more at risk for the development of PPD. Women who experienced childhood adversity, such as neglect and abuse, also bring with them an increased risk for the development of PPD. These underlying psychological patterns play an important role in the way the woman perceives the demands of her new role as a mother and her ability to seek help when she needs it [3], [9].

Another important factor is the role of culture. It is believed to play a significant role in the risk factors. Cultural factors may affect women in terms of motherhood, which may prevent them from showing emotional symptoms. Immigrant women and those belonging to minority ethnic groups may experience additional difficulties. These difficulties may arise because of language, acculturation, and lack of access to appropriate mental health care. [7], [17].

The cumulative effect of these risk factors is particularly worrying. A woman who is subjected to several risk factors may have a greater likelihood of developing severe postpartum depression or anxiety disorders. This is particularly worrying because it highlights the need for a comprehensive assessment of risk factors and not taking them in isolation. The knowledge of these risk factors is important for health care providers to identify those mothers who are most likely to develop postpartum depression and anxiety disorders and take appropriate measures to prevent the severity of the symptoms. [22].

Diagnosis and Screening Tools for Postpartum Depression and Anxiety

Postpartum depression and anxiety are conditions that require prompt attention for proper treatment and the prevention of complications. However, these conditions are not being adequately addressed due to a lack of proper diagnosis of the conditions. This is attributed to the fact that the symptoms are being confused with normal postpartum changes [11].

Clinical diagnosis generally involves a thorough assessment, which includes a medical history, mental status, and observation of emotional and behavioral changes. The healthcare provider will also assess the mother's ability to care for her child, sleep, appetite, and energy levels. If symptoms persist after two weeks, a formal assessment is advised .

The Edinburgh Postnatal Depression Scale (EPDS) is a screening tool most commonly used to assess for depression in postpartum women. It is a 10-item questionnaire designed to identify depression in postpartum women, with higher numbers indicating higher risk [5]. The Patient Health Questionnaire-9 (PHQ-9) is another common tool that assesses depression severity based on symptoms like sadness, loss of interest, sleep disturbances, and concentration problems [6]. For anxiety, the Generalized Anxiety Disorder-7 (GAD-7) scale is frequently used to evaluate worry, nervousness, and difficulty relaxing [6].

The Postpartum Depression Screening Scale (PDSS) offers a broader assessment of emotional and psychological symptoms, including emotional instability, cognitive changes, and feelings of guilt related to motherhood [5]. Beyond standardized tools, clinical interviews remain vital for confirming diagnosis, evaluating severity, and ruling out other psychiatric conditions [10].

Many health organizations recommend routine screening during antenatal and postpartum visits to

facilitate early intervention [11]. However, due to the stigma attached to mental health issues, mothers may not open up about their condition. Thus, there is a need to create awareness among health professionals and the general public to encourage mothers to open up about their condition. [10].

The time and rate at which screening is performed also determine the accuracy of the results. Studies indicate that screening must be performed on multiple occasions during the perinatal period, including the third trimester, the initial postpartum visit, and then again between three to six months post-delivery. This helps to detect those who develop symptoms during the postpartum period rather than immediately following birth. Digital screening tools, such as mobile apps and online self-screening tools, have also been found to be effective adjuncts to traditional face-to-face screening methods. This is particularly important for those living in rural areas who feel uncomfortable disclosing emotional issues in a traditional face-to-face setting [11].

In recent times, healthcare facilities have started embracing the idea of universal screening to ensure that every mother is screened for mental health issues, regardless of the level of perceived risk. This helps to eliminate disparities in the early detection of the disorder. It also increases the chances of reaching vulnerable populations who might not even attempt to access medical services. Training the medical personnel to be culturally sensitive in the administration of the tests is also important to ensure the success of the program [10].

Impact of Postpartum Depression and Anxiety on Mother and Infant

If not managed, postpartum depression and anxiety have serious effects on both the mother and the newborn. Maternal mental health in this period is a fundamental factor that influences the psychological and physical health of both [9].

For the mother, depression is characterized by feelings of hopelessness, tiredness, and lack of motivation to participate in daily activities, including self-care and childcare [8]. It can also limit her capacity to develop a strong emotional attachment with her child, which is crucial in the early stages of a child's development . Emotional unavailability can limit a mother's response to her child's needs, which can limit a child's emotional development. The duration of breastfeeding can also be limited by depression; depression has been associated with early termination of breastfeeding [8].

Apart from the emotional and bonding problems, untreated PPD can also result in various health problems for the mother, such as sleep problems, worsening of existing medical conditions, and an increased risk of future episodes of depression. All these problems can accumulate and result in long periods of disability, which can affect the mother's ability to go back to work or participate in meaningful social relationships. Furthermore, untreated anxiety disorders in mothers can result in maladaptive coping strategies, such as avoidance behaviors, which can negatively affect the confidence and competence of the parents [3], [9].

The infant is equally at risk too. Behavioral problems may occur in children whose mothers are depressed, and they may face a risk of cognitive problems in later stages too. The mother's anxiety can make her overly concerned about her child's health, causing her constant distress and inability to relax and seek proper rest [14]. This heightened anxiety can also affect family dynamics, as partners may experience emotional strain and conflicts may arise [16].

Timely treatment of postpartum depression and anxiety is therefore essential—not only for the mother's health but also to support the child's

development and maintain a stable family environment [10].

Management and Treatment of Postpartum Depression and Anxiety

Effective management of postpartum depression and anxiety requires a combination of psychological, pharmacological, and supportive strategies, tailored to the severity of symptoms and individual needs [9].

For mild cases, early detection and supportive counselling are often sufficient. Healthcare professionals provide emotional support, education, and reassurance, which can reduce feelings of isolation and encourage women to seek further help if needed [10].

Psychological therapies are the first-line treatment for mild to moderate symptoms. Cognitive behavioural therapy (CBT) helps women identify and change negative thought patterns and develop healthier coping strategies, significantly reducing symptoms of both depression and anxiety [11]. Interpersonal therapy (IPT) is based on enhancing communication and strengthening social support networks for the mother .

In cases of moderate to severe symptoms, pharmacological intervention may be required. Selective serotonin reuptake inhibitors (SSRIs), such as sertraline and fluoxetine, are considered to be effective .

The risks and benefits are carefully considered for breastfeeding women [9]. The drug "Brexanolone," which has been approved by the FDA for the treatment of postpartum depression, targets neuroactive steroids. It has shown promise in treating severe cases of postpartum depression.

Support groups can also help in the management of postpartum depression. In this way, mothers can share their experiences, reducing feelings of stigma and loneliness [10].

Lifestyle changes such as adequate sleep, nutrition, exercise, mindfulness, and relaxation can help in managing postpartum depression [21]. Involving family members in treatment is equally important; partners and relatives can provide emotional support, assist with childcare, and help create a supportive environment for recovery [17].

A stepped care approach is recommended, which means the level of treatment is gradually stepped up depending on the woman's response. This method is important because it ensures the best use of resources while still providing high-intensity treatment to those who really need it. Regular follow-up sessions with the patient are important to monitor the patient's progress, adjust treatment as needed, and address any new issues. For women who do not sufficiently respond to the initial treatment methods, combination treatment using both psychotherapy and medication is recommended [9], [10].

Nursing Management and Supportive Care

Nurses have a significant role to play in the early detection, management, and prevention of postpartum depression and anxiety. This is due to the fact that nurses are the primary point of contact for pregnant women and new mothers and are thus better positioned to notice behavioral changes that may be indicative of postpartum depression and anxiety [10].

One of the key nursing roles is to carry out early detection by utilizing tools such as EPDS during antenatal and postnatal consultations. Through the provision of a supportive and nonjudgmental environment, the mother may feel free to open up about her emotional problems and overcome the stigma surrounding mental health. Education is another critical component; nurses can inform mothers and families about the emotional changes expected postpartum and the importance of seeking help when symptoms arise [1].

Encouraging family involvement in postpartum care helps ensure mothers receive both emotional and practical support. Nurses can guide families on

how to assist with childcare responsibilities and provide emotional encouragement [17]. Promoting healthy lifestyle practices—such as adequate rest, good nutrition, and gentle exercise—also contributes to better mental health outcomes [21].

Aside from direct patient care, nurses can function as advocates for the mother's mental health in the healthcare setting. They can work with the mother, the obstetrician, the pediatrician, and the mental health practitioner to ensure the mother receives the best care. Documenting emotional symptoms during routine visits and checking up with the mother at risk through telephone contact and/or home visits can help improve the mother's outcome. Nurses can play a significant role in destigmatizing the experience of seeking help, making the mother feel that her mental health issues in the postpartum period are common and treatabl [9], [10].

The mothers suffering from severe symptoms should be referred to support groups or mental health professionals such as psychologists and psychiatrists. Through screening, education, emotional support, advocacy, and referrals, nurses play a vital role in maintaining the health of mothers [10].

Prevention Strategies for Postpartum Depression and Anxiety

Prevention is the backbone of the care process for the mental health of mothers. Good prevention programs involve the identification of risk factors, psychological support, and awareness.

Routine screening during pregnancy enables the healthcare provider to monitor women with a history of depression, anxiety, or high levels of stress [5]. Antenatal education and counselling can also be highly effective. Educating mothers about the emotional changes after childbirth, coping mechanisms, and available support services helps reduce anxiety and ease the psychological transition to motherhood[10].

Strengthening social support networks is equally important. Support from partners, family, and friends can buffer stress and reduce the likelihood of developing severe anxiety or depression [17]. Good lifestyle habits such as sufficient sleep, healthy nutrition, and exercise, combined with the practice of mindfulness and relaxation techniques, can also contribute to emotional stability and help mothers cope with the challenges of early parenting [21].

Community-based programs and support groups provide mothers with an opportunity to share their experiences and get support, which can help alleviate feelings of isolation and reduce risk levels [10]. Addressing the stigma associated with mental health among mothers is another important aspect. This will help mothers feel free to seek help without fear of stigmatization, which can help them get the help they need.

The healthcare system should provide mothers with the opportunity to get mental healthcare. This can be achieved by training primary healthcare providers to recognize early signs of mental health problems and ensure that there are referral pathways to mental healthcare providers [1], [9]. Additionally, programs that include home visits by trained nurses or community health workers may offer support during the postpartum period when the mother is most vulnerable. The visits may offer continuous monitoring and assistance in caring for the baby and opportunities to strengthen coping mechanisms.

CONCLUSION

The condition of postpartum depression and anxiety is a common mental health condition that has been affecting a large number of women in the first year following childbirth. The condition has been caused by a combination of different factors. If not addressed, it has serious implications for the mother and child.

The postpartum period is characterized by a number of changes in the hormones of the mother, changes in lifestyle, and emotional changes. All these changes have implications for the mother. The condition of postpartum depression and anxiety has serious implications for the mother. The mother is unable to take care of herself due to the condition.

The condition of postpartum depression and anxiety can be addressed through early identification. The condition can be identified through the use of standardized instruments such as EPDS and PHQ-9. The condition has been addressed through the use of cognitive behavioral therapy, interpersonal therapy, and medication. Family support has also been essential in helping mothers cope with the condition.

Nurses and other health professionals play an important role in the promotion of maternal mental health. They are best placed to detect early warning signs of mental health problems through close interaction with pregnant women during antenatal and postnatal care.

Preventive measures such as antenatal education, building support networks, and educating the public about maternal mental health can help alleviate the symptoms of postpartum depression and anxiety.

It is important to tackle the issue of postpartum depression and anxiety in order to promote the mental health of the mother and the healthy growth of the child. This can be achieved through awareness, improved healthcare facilities, and early intervention to help the mother and the child worldwide.

Looking forward, further investment in research, policy development, and strengthening of the health care systems is required to maintain the progress made in the field of maternal mental health. The focus of future work should be on reducing disparities in access to care and developing culturally sensitive interventions and delivering them in primary care settings. The long-term payoff of such investment will not only be for the individual mother but will have a positive impact on the community and society as a whole by reducing the burden of untreated perinatal mental health illness.

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