Rom J Leg Med [31] 213-219 [2023]
DOI: 10.4323/rjlm.2023.213

ETHICAL AND LEGAL APPROACH IN CHOOSING POSTPARTUM DEPRESSION MANAGEMENT

Oana-Denisa Bălălău[1,2], Răzvan-Valentin Scăunașu[1,3,*], Cristian Bălălău[1,4], Octavian-Gabriel Olaru[1,2], Ion Motofei[1,4], Nicolae Bacalbașa[1,5], Mircea Lupușoru[1]

[1]"Carol Davila" University of Medicine and Pharmacy, [2]"Bucur" Maternity, "St. Ioan " Emergency Clinical Hospital, [3]"Colțea" Clinical Hospital, [4]"St. Pantelimon" Emergency Clinical Hospital, [5]"Dr. I. Cantacuzino" Clinical Hospital, Bucharest, Romania

Abstract: Postpartum depression (PPD) is a common complication of childbirth and causes a major public health problem, affecting 10-15% of mothers globally each year. Untreated, maternal depression has multiple potential negative effects on maternal-infant attachment, child development, married life, interaction with others, and social integration, which in some cases can lead to suicidal ideation.

Being a psychiatric disorder, postpartum depression benefits from the support of the Romanian state through law 487/2002. It provides access to specialized treatment centers, makes an individualized diagnosis based on the psychiatric history of each patient and establishes a phased treatment, with specialized monitoring and periodic evaluations. However, several studies in the literature demonstrate patient's reluctance to acknowledge the presence of PPD symptoms and refuse treatment, especially medication, but most women diagnosed with PPD opt for psychotherapy.

The psychotherapist's approach is adapted to each situation, being specific to the case. It is very important that the patient's informed consent is strictly observed, and that the cases of deviation from it be strictly legal, which the patient has become aware of.

Keywords: postpartum depression, psychotherapist, informed consent, interpersonal psychotherapy.

INTRODUCTION

The birth of a child is a happy event for the mother and her family. The postpartum period brings many changes in a woman's life, from hormonal changes that occur during pregnancy and worsen after birth, to changes in married life, environmental and emotional perceptions [1-2]. In the postpartum period, women face an elevated risk of developing or recurring psychiatric conditions. Patients may encounter postpartum blues, marked by mild depressive symptoms, typically self-limiting, or more severe minor or major depressive syndromes. Untreated postpartum depression can have adverse consequences for both mother and child [3-6]. Postpartum psychosis (or puerperal psychosis) is commonly observed in individuals diagnosed with bipolar disorder, but it can also manifest in women with major depression featuring psychosis, schizophrenia, or schizoaffective disorder. In 50% of patients with postpartum depression, the onset of the first symptoms is during pregnancy.

The primary risk factor is the patient's personal history of depression. Other contributing factors include genetic susceptibility, hormonal changes, as well as psychological and social problems [1, 7]. Postpartum psychiatric disorders are associated with adverse effects on infant and infant development [8 - 11].

Mental health is a fundamental component of individual health and is a major goal of public health policy (art. 1, law 487/2002). The prevalence of postpartum unipolar major depression in the United States and Europe is about 9%, with the rate being higher in underdeveloped countries.

Also, the anxiety caused by the COVID 19 pandemic, social distress measures and difficult access to health services could have been the cause of this exacerbation [12].

*Correspondence to: Răzvan-Valentin Scăunașu, "Carol Davila" University of Medicine and Pharmacy, 8 Eroii Sanitari Blvd., 050474, Bucharest, Romania, E-mail: razvan.scaunasu@umfcd.ro

MATERIAL AND METHODS

The paper is an analysis of the literature on the treatment options of patients diagnosed with postpartum depression and its access to medical services provided free of charge by law. The paper reviewed several studies that resulted in increased compliance of patients with PPD for psychotherapy, to the detriment of drug treatment. The ethical, moral and legal limitation of the relationship between the patient and the psychotherapist was analyzed.

DISCUSSION

The clinical manifestations of postpartum depression are comparable to the characteristics of depressive episodes that occur outside the postpartum period.

Postpartum depression management involves a multimodal approach [13]. It is important to determine whether the treatment is performed on an outpatient or inpatient basis and requires careful assessment of the patient's mental health. This is done with the free documented and informed consent of the person, except for the specific situations, established by law. If the person has difficulty assessing the implications of a decision, he or she may be assisted by his or her personal or legal representative. (art. 11, law 487/2002) Informed consent for therapy is essential because it ensures that the patient's decision to take part in psychotherapy is informed, voluntary and rational [14]. Although it is assumed that the patient's request for the therapist's help with his or her problems means implicit consent, this does not amount to "informed consent." Informed consent should be seen as the primary means of protecting patient's self-determination and self-government rights, as it gives them the opportunity to make an informed decision about engaging in psychotherapy, communicates respect for the individual and reflects the collaborative nature of psychotherapy. Appropriate informed consent procedures can reduce the patient's anxiety by demystifying the therapeutic process [14-15].

The assessment of mental health is carried out by direct examination of the person concerned only by the psychiatrist. (paragraph 1, art. 10, law 487/2002) and it will be performed in mental health institutions accredited according to the law. (paragraph 2, art. 10, law 487/2002) The evaluation of the mental health condition is carried out at the request of the person, during his / her voluntary hospitalization in a psychiatric unit or at the express request of some authorized institutions, under the conditions of a forced hospitalization (art. 12, law 487/2002), and the purpose of the evaluation is to establish the diagnosis. (paragraph 1, art. 13, law 487/2002). Only in certain cases specified by law does the assessment have as objectives the determination of mental capacity and discernment, the establishment of danger to oneself or others, the determination of the degree of incapacity and mental disability. (paragraph 2, art. 13, law 487/2002)

The diagnostic criteria for a major depressive episode (MDE) specified in the Diagnostic and Statistical Manual (DSM-IV) are the same for every period postpartum included and consists in persistent low mood or anhedonia for at least 2 weeks. Along with that, there should be present four or more of the following signs: increased or decreased appetite, sleep disturbances, a state of anxiety or psychomotor retardation, adynamia, low concentration, low self-esteem and suicidal thoughts [16].

By far, depression seems to be the most important risk factor for suicidal behavior. Worth mentioning that psychological autopsy studies suggest that at least 90% of the victims are fulfilling the criteria for a mental disorder at the time of suicide. Also, gender seems to be influencing the choice of suicide method. Usually, women tend to choose less violent and less lethal methods of suicide, like poisoning [17].

If a major depressive episode debuts with depressive symptoms in the first month after birth, it can be classified as having a postpartum onset. However, studies suggest that depressive episodes are significantly more common in women in the first three months after birth and an increased vulnerability to psychiatric illness may persist for a year or more [18 - 19]. It is paramount that PPD should be differentiate from other psychiatric and non-psychiatric diagnoses.

In assessing mental health, the psychiatrist does not take in to account non-clinical criteria, such as: social, , religious, family or professional conflicts or nonconformism towards moral, social, cultural, political or religious values, dominant in society, racial, political and economic (paragraph 1, art. 14, law 487/2002)

Coping with the dilemma of choosing between psychotherapy, antidepressants or combining them with minimal systematic research that compares these ways to guide them, it is a problem that women with PPD, their families and their clinicians must face. The key factors that govern the treatment are diverse and include knowledge of untreated maternal diseases and

available treatments, risk perception, and the actual individual beliefs [20].

If, after assessing the state of mental health, the psychiatrist finds the presence of a mental disorder, the diagnosis should be made in accordance with the present classification of the World Health Organization. (paragraph 1, art. 15, law 487/2002).

The evaluation's outcome must align with medical principles and procedures, documented in medical records, and conveyed to the individual, their personal or legal representative, or, upon explicit request, legal authorities (paragraph 2, art. 15, law 487/2002).

Individuals undergoing mental health assessments are entitled to information confidentiality, except as stipulated by law (paragraph 1, art. 16, law 487/2002). The person or their legal representative holds the right to contest the assessment result, request a review, and have it repeated (paragraph 2, art. 16, law 487/2002).

Throughout the follow-up of the psychiatric patient, the monitoring of the symptoms and the response to the psychiatric medication will be ensured if it has been prescribed, as well as the assistance of the psychotherapist for the patient, but also for the people who care for her.

Women with depression report that there is a major difference between the social support they want in the postpartum period and the one they perceive that they have received. This lack of support is more perceived by women in their relationships with their partners than in that with relatives and friends. The relationship between patients and their male spouses is described to be more pronounced in postpartum women who suffer from depression than those without depression [21].

The depressed spouse perception that her husband do not support her properly it is often not share by the latter. Interactions within dysfunctional families in a family stress setting may also contribute to this. Most of the time women do not receive adequate support from their family, which can also lead to guilt ("you don't know how to keep your husband") [22].

To aid families grappling with depression-related issues, the Ministry of Health and Family has instituted the National Program for Mental Health and Prophylaxis in Psychiatric and Psychosocial Pathology (art. 4 of law 487/2002). As outlined in art. 20 of law 487/2002, individuals with psychiatric disorders under outpatient care, irrespective of their social status, are entitled to free medical assistance and medications covered by the Single National Health Insurance Fund.

Effective management of maternal depression is paramount. Postpartum depression (PPD) is a significant but treatable maternal depressive disorder [23-26]. Untreated, it poses a heightened risk of stressful life events, prenatal anxiety, strained marital relationships, impaired child development, and even suicide [27-31].

A type 2 cohort study conducted at St. John's Emergency Clinical Hospital, Maternity Happy January 2017-2018 compared the stress associated with vaginal birth versus cesarean delivery. We included 78 patients who experienced both ways of giving birth. Most associated with an increased level of pain was vaginal birth, followed by high stress, anxiety and manifestations of PPD [32]. A similar study conducted in the same clinic looked at the psychosocial impact of childbirth in primiparous women and found that the vaginal birth experience is often described as negative, with many mothers saying they no longer want children [33]. Going through a perinatal traumatic experience can lead to anxiety with a major impact on the mother-newborn relationship.

There are studies on how depressive disorder interferes with the good consolidation of the mother-child relationship. An experiment performed by Forman et al. checked whether the psychotherapeutic treatment offered to mothers with postpartum depression resulted in parental improvement and child development. The study group included a group of patients with postpartum depression undergoing psychotherapy and a comparison group of women without depression.

At the 6-month mark, mothers affected by depression exhibited lower receptiveness toward their children, reported higher levels of parental stress, and held a more negative view of their children compared to mothers without depression.

Psychotherapy reduced parental stress, but it remained high among patients with depression compared to the control group. Eighteen months later, depressed mothers showed less attachment to the baby than non-depressed mothers.

Early negative maternal perceptions of the child predicted negative temperament and behavioral problems at 18 months after treatment. Postpartum depression treatment should target the mother-child relationship in addition to the mother's depressive symptoms. [34]

Women with PPD often associate self-neglect and risk-related behaviors, including excessive drinking, use of illegal substances and smoking [35

- 36]. The newborn and other family members may also be negatively influenced by the mother's PPD. Other studies demonstrated that untreated PPD can undermine the infant-maternal connection, infant cognitive and motor development, and has been associated with disorders during childhood and adolescence, mainly consisting in behavioral and learning difficulties [37-40].

For the best possible outcome in the treatment of postpartum depression, several clinicians have combined cognitive-behavioral therapy, psychoeducation, psychotherapy, acupuncture, Chinese herbal medicine, and exercise. [41-47] The results showed low efficacy.

Although the results in these cases are very limited, electroconvulsive therapy (ECT) emerged as a treatment option for postpartum depressed women who have severe or psychotic symptoms or do not have a proper response to antidepressants. Some studies have reported that transcranial magnetic stimulation (TMS) and fluoxetine may effectively treat PPD, but their safety is still unknown in the literature [48 - 54].

There are studies that have examined the options for treating PPD and have shown variations in preferences for the type of health professionals, the type of treatment and the place of treatment, which differ depending on the geographical area of residence of the mother. In relation to that, a study in the United States found that elderly mothers were more likely to accept PPD therapy than younger mothers. [55] Another study that made a comparison Caucasian and African American mothers, have revealed that the last ones expressed low confidence in medications and preferred to receive counseling for their PPD symptoms from religious figures in the community. [56]. The results of another study pointed the fact that educated, married women with higher socioeconomic status undergo individual psychotherapy for their PPD symptoms, instead of group therapy [57].

A cross-sectional study that took place in eight maternal and child health clinics (MCHC) in central Israel (December 2014 and August 2015) had included 1,000 mothers who participated in their child's first medical examination nine weeks after birth. Study participants completed a 10-question questionnaire to assess PPD symptoms according to the Edinburgh Postnatal Depression Scale (EPDS) [58]. The questions in the questionnaire focus on mothers' feelings during the perinatal period. 4-point on Likert scale were given to each question. The tenth question is about self-harm [59], and 1% of mothers said in response to that question that they were thinking of getting hurt. Other questions in the questionnaire referred to where patients want PPD therapy and the type of therapy they would choose. Patients diagnosed with PPD ranked second in community treatment centers compared to women from control lot who ranked first. Preferred therapists were psychologists, alternative therapists, and family physicians, with personal meetings in a private practice, home visits, and community meetings under the guidance of a professional being the first three preferred services. [60]

Interpersonal psychotherapy is the golden rule of treatment for postpartum depression and should be considered as a first option, especially for depressed lactating women [61].

Drug treatment options are related to the lack of prospective and controlled data on potential short- and long-term adverse effects in infants who are breastfed and therefore exposed to antidepressants. Despite many studies revealing minimal or no short-term side effects in infants, many mothers are reluctant to take treatment. [62-64] Another study showed that 31% of women breastfeeding with PPD refused antidepressants because they were breastfeeding [65].

PPD patients who present a lower adherence to treatment are one with greater risk for poorer short-term outcomes. Therefore, there was an increased risk for postoperative complications in patients who had relevant and important symptoms of depression before undergoing surgery, followed by numerous medical checks after hospital discharge [66].

A recent review pointed out that psychotherapy, when available, had been preferred over antidepressants as a first intention treatment by the patients with major depressive disorder [67]. Also, this is the main choice of treatment in case of postpartum women [66]. A study that looked at patient's choice of treatment showed that more women with PPD chose psychotherapy over drug treatment, especially when breastfeeding, and the results were similar in treatment groups with antidepressant therapy alone or combined [68].

It is a fact that now days women worldwide are share their opinions regarding their experiences in online media. Although social media discussions could have positive effects in spreading the individual experiences throughout a community, the doctor should be the one to guide the patient, both in terms of diagnostic and best suitable treatment for each patient, and in disease awareness [69].

In interpersonal therapy, both patient and doctor, they will select one of four areas with

interpersonal problems (role transition, role dispute, pain, or interpersonal deficits) as a treatment focus. During therapy, that could usually take 12 to 20 weeks, treatment strategies are followed to help patients change problematic approaches to relationships and build better social supports. Therapy addresses issues relevant to postpartum depression, such as the mother-child relationship, mother-to-partner, and the transition back to work [70].

The therapy focuses on the patient's problems and is based on confidentiality, important features that match the requirements of the mother with postpartum depression. Without ensuring confidentiality, patients cannot be expected to debate the embarrassing aspects of their lives, which are sometimes harmful to themselves [71].

As part of the medical profession, therapists are required to maintain the confidentiality of their patients. However, it is important to remember that the ethical requirement of confidentiality overlaps with the law, so the answers to some of the situations can only be predicted through an understanding of both ethics and the law. Therefore, in situations where things are not clear, the therapist should seek legal advice. It is important to take in to account the exceptions to the confidentiality of the law. Exception information should be part of both the informed consent procedure and the therapeutic contract, as otherwise both the therapist and the therapist may be at significant risk [72]. In the United States, there are provisions in the law whereby the therapist is free to decide what to disclose or not to disclose about the information obtained during psychotherapy. From an ethical point of view, it is important for therapists to be aware of their responsibility to patients. He must maintain professional limits, have the necessary skills, knowledge, training, and experience in a certain type of therapy, be aware of his emotional state while dealing with patients and maintain the confidentiality of what is discussed, written, or recording during therapy.

In conclusion, postpartum depression is more common in women with a history of psychiatric disorders, and the clinical manifestations are comparable to depressive episodes that occur outside the postpartum period.

The incidence of PPD is higher in low- and middle-income countries.

The Romanian state provides free access to specialized medical services to patients with psychiatric disorders through law 487/2002.

Patients with symptoms of PPD often refuse to be recognized, which delays the initiation of treatment.

Most women are cautious about taking medication, with the main concern being the exposure of the fetus to antidepressants through breast milk and often prefer interpersonal psychotherapy, which is considered a first-line treatment, being recommended both as a single therapy and in combination with drug therapy.

When a patient consults a psychotherapist, they must agree and agree on the limitations of confidentiality in relation to the law in force.

Conflict of interest

The authors declare that they have no conflict of interest.

References

1. O'Hara MW, McCabe JE. Postpartum depression: current status and future directions. Annu Rev Clin Psychol. 2013; 9:379.
2. Meltzer-Brody S. New insights into perinatal depression: pathogenesis and treatment during pregnancy and postpartum. Dialogues Clin Neurosci. 2011; 13:89.
3. Howard LM, Molyneaux E, Dennis CL, Rochat T, Stein A, Milgrom J. Non-psychotic mental disorders in the perinatal period. Lancet. 2014;384(9956):1775-1788
4. Stein A, Pearson RM, Goodman SH, Rapa E, Rahman A, McCallum M, Howard LM, Pariante CM. Effects of perinatal mental disorders on the fetus and child. Lancet. 2014;384(9956):1800-1819.
5. Howard LM, Piot P, Stein A. No health without perinatal mental health. Lancet. 2014; 384:1723.
6. Grigoriadis S, VonderPorten EH, Mamisashvili L, Tomlinson G, Dennis CL, Koren G, Steiner M, Mousmanis P, Cheung A, Radford K, Martinovic J, Ross LE. The impact of maternal depression during pregnancy on perinatal outcomes: a systematic review and meta-analysis. J Clin Psychiatry. 2013;74(4):e321-341.
7. Couto TC, Brancaglion MY, Alvim-Soares A, Moreira L, Garcia FD, Nicolato R, Aguiar RA, Leite HV, Corrêa H. Postpartum depression: A systematic review of the genetics involved. World J Psychiatry. 2015;5(1):103-111.
8. O'Hara MW, Wisner KL. Perinatal mental illness: definition, description and aetiology. Best Pract Res Clin Obstet Gynaecol 2014; 28:3.
9. National Institute for Health and Care Excellence (NICE). Antenatal and postnatal mental health: clinical management and service guidance. NICE clinical guideline 192. December 2014. http://www.nice.org.uk/guidance/cg192 (Accessed on January 28, 201)
10. Stein A, Pearson RM, Goodman SH, Rapa E, Rahman A, McCallum M, Howard LM, Pariante CM. Effects of perinatal mental disorders on the fetus and child. Lancet. 2014;384(9956):1800-1819.
11. Meaney MJ. Perinatal Maternal Depressive Symptoms as an Issue for Population Health. Am J Psychiatry. 2018; 175:1084.
12. Lupușoru M, Scăunașu R-V, Bălălău C, Lupușoru G, Cristache C, Badiu Cd, Bălălău OD. Legal Challenges of Medical Practice During the Covid-19 Pandemic, RJLM. 2021; 29(3):305-308.
13. Uzun ND, Tekin M, Uzun F. A comprehensive analysis of postpartum depression and delivery characteristics: a cross-sectional study. J Mind Med Sci. 2021; 8(1): 94-99.
14. Bennett BE, Bricklin PM, Harris E, Knapp S, VandeCreek. L, Younggen, JN. Assessing and managing risk in psychological practice: An individualized approach. Rockville, MD: The Trust. 2006.

15. Beahrs JO, Gutheil TG. Informed consent in psychotherapy. American Journal of Psychiatry. 2001; 158: 4–10.
16. American Psychiatric Association. Diagnostic and Statistical Manual for Psychiatric Disorders. 4th Ed. Washington, DC: American Psychiatric Association; 2000. Text Revision.
17. Constantin AM, Lupusoru MOD. Socio-demographic and economic characteristics of patients with psychiatric pathology and non-fatal suicidal behavior. RJLM. 2015;23(3):217-220.
18. New parents and mental disorders: a population-based register study. Munk-Olsen T, Laursen TM, Pedersen CB, Mors O, Mortensen PB JAMA. 2006; 296(21):2582-2589.
19. Kendell RE, Wainwright S, Hailey A, Shannon B. The influence of childbirth on psychiatric morbidity. Psychol Med. 1976; 6(2):297-302.
20. Sit DK, Wisner KL Decision Making for Postpartum Depression Treatment.Psychiatr Ann. 2005; 35(7):577-584.
21. O'Hara MW. Postpartum depression: Causes and consequences. Springer-Verlag; New York: 1994.
22. Velea OP, Trutescu C, Curca GC. Psychosocial factors associated to violence against women. RJLM. 2015;23(3):221-226.
23. Stewart DE, Vigod S. Postpartum depression. N Engl J Med 2016;375:2177-2186.
24. Sriraman NK, Pham DQ, Kumar R. Postpartum depression: what do pediatricians need to know?Pediatr Rev. 2017;38:541-551.
25. Šebela A, Hanka J, Mohr P. Etiology, risk factors, and methods of postpartum depression prevention. Ceska Gynekol 2018;83:468-473.
26. Stewart DE, Vigod SN. Postpartum depression: pathophysiology, treatment, and emerging therapeutics. Annu Rev Med. 2019;70:183-196.
27. Bălălău OD, Olaru OG, Dumitru AV, Păunică I, Stănescu AD. Maternal infections with an increased risk of transmission to the foetus; a literature review. J Clin Invest Surg. 2020; 5(2): 66-72.
28. Qobadi M, Collier C, Zhang L. The effect of stressful life events on postpartum depression: findings from the 2009-2011 Mississippi pregnancy risk assessment monitoring system. Matern Child Health J2016;20: Suppl 1: 164-172.
29. Farías-Antúnez S, Xavier MO, Santos IS. Effect of maternal postpartum depression on offspring's growth. J Affect Disord 2018;228:143-152.
30. Lindahl V, Pearson JL, Colpe L. Prevalence of suicidality during pregnancy and the postpartum. Arch Womens Ment Health 2005;8:77-87.
31. Kirpinar I, Gözüm S, Pasinlioğlu T. Prospective study of postpartum depression in eastern Turkey prevalence, socio-demographic and obstetric correlates, prenatal anxiety and early awareness. J Clin Nurs. 2010;19:422-431.
32. Olaru OG, Stanescu AD, Raduta C, Ples L, Vasilache A, Bacalbasa N, Vasilache A, Balalau OD. Caesarean section *versus* vaginal birth in the perception of woman who gave birth by both methods. J Mind Med Sci. 2021; 8(1): 127-132.
33. Balalau OD, Olaru OG, Bacalbasa N, Paunica S, Balan DG, Stanescu AD. An analysis of risk factors associated with women's urinary incontinence; literature review. J Mind Med Sci. 2021; 8(1): 53-59.
34. Forman D, O'Hara M, Stuart S, Gorman L, Larsen K, Coy K. Effective treatment for postpartum depression is not sufficient to improve the developing mother–child relationship. Development and Psychopathology. 2007; 19(2): 585-602.
35. Wisner KL, Chambers C, Sit DKY. Postpartum depression: a major public health problem. J Am Med Assoc. 2006;296(21):2616-2618.
36. Pană M, Sima RM, Bălălău OD, Stănescu AD, Pleș L, Poenaru MO. The quality of sexual life after vaginal surgical interventions. J Mind Med Sci. 2020; 7(2): 201-205.
37. Akman I, Kusçu K, Ozdemir N, Yurdakul Z, Solakoglu M, Orhan L, Karabekiroglu A, Ozek E. Mothers' postpartum psychological adjustment and infantile colic. Arch Dis Child. 2006;91(5):417-419.
38. Balalau OD, Conea IM, Bacalbasa N, Dumitriu AS, Paunica S, Vasilache A, Olaru OG. Management of hemoperitoneum due to rupture of the ovarian cyst. J Clin Invest Surg. 2021; 6(1): 6-10.
39. Diego MA, Field T, Hernandez-Reif M, Cullen C, Schanberg S, Kuhn C. Prepartum, postpartum, and chronic depression effects on newborns. Psychiatry. 2004;67(1):63-80.
40. Goodman JH. Paternal postpartum depression, its relationship to maternal postpartum depression, and implications for family health. J Adv Nurs. 2004;45(1):26-35.
41. Thomson M, Sharma V. Therapeutics of postpartum depression. Expert Rev Neurother 2017;17:495-507.
42. Downs DS, DiNallo JM, Kirner TL. Determinants of pregnancy and postpartum depression: prospective influences of depressive symptoms, body image satisfaction, and exercise behavior. Ann Behav Med. 2008;36:54-63.
43. Li W, Yin P, Lao L, Xu S. Effectiveness of Acupuncture Used for the Management of Postpartum Depression: A Systematic Review and Meta-Analysis. Biomed Res Int. 2019;2019:6597503.
44. Yang L, Di YM, Shergis JL, Li Y, Zhang AL, Lu C, Guo X, Xue CC. A systematic review of acupuncture and Chinese herbal medicine for postpartum depression. Complement Ther Clin Pract. 2018;33:85-92.
45. Li S, Zhong W, Peng W, Jiang G. Effectiveness of acupuncture in postpartum depression: a systematic review and meta-analysis. Acupunct Med. 2018;36(5):295-301.
46. Balalau OD, Loghin MG, Vasilache S, Olaru OG, Paunica I, Conea IM. Uterine submucosal leiomyomas: modern diagnosis and miniinvasive surgery. J Clin Invest Surg. 2021;6(2):88-93.
47. Hou Y, Hu P, Zhang Y, Lu Q, Wang D, Yin L, Chen Y, Zou X. Cognitive behavioral therapy in combination with systemic family therapy improves mild to moderate postpartum depression. Braz J Psychiatry. 2014;36(1):47-52.
48. Garcia KS, Flynn P, Pierce KJ, Caudle M. Repetitive transcranial magnetic stimulation treats postpartum depression. Brain Stimul. 2010;3(1):36-41.
49. Myczkowski ML, Dias AM, Luvisotto T, Arnaut D, Bellini BB, Mansur CG, Rennó J, Tortella G, Ribeiro PL, Marcolin MA. Effects of repetitive transcranial magnetic stimulation on clinical, social, and cognitive performance in postpartum depression. Neuropsychiatr Dis Treat. 2012;8:491-500.
50. Cox EQ, Killenberg S, Frische R, McClure R, Hill M, Jenson J, Pearson B, Meltzer-Brody SE. Repetitive transcranial magnetic stimulation for the treatment of postpartum depression. J Affect Disord. 2020;264:193-200.
51. Roy A, Cole K, Goldman Z, Barris M. Fluoxetine treatment of postpartum depression. Am J Psychiatry. 1993;150(8):1273.
52. Kashani L, Eslatmanesh S, Saedi N, Niroomand N, Ebrahimi M, Hosseinian M, Foroughifar T, Salimi S, Akhondzadeh S. Comparison of Saffron *versus* Fluoxetine in Treatment of Mild to Moderate Postpartum Depression: A Double-Blind, Randomized Clinical Trial. Pharmacopsychiatry. 2017;50(2):64-68.
53. Gobinath AR, Richardson RJ, Chow C, Workman JL, Lieblich SE, Barr AM, Galea LAM. Voluntary running influences the efficacy of fluoxetine in a model of postpartum depression. Neuropharmacology. 2018;128:106-118.
54. Zhang Y, Zhang T, Tong CY, et al. Effect of repeated transcranial magnetic stimulation combined with antidepressant drugs on cognitive function and breastfeeding of postpartum depression patients. Int J Psychiatry 2018;45:323–326.
55. Garry J, Kim H, Sheng X, Egger M, Baksh L. Postpartum depression and help-seeking behavior. J Midwifery Women's Heal. 2009;54(1):50-56.
56. O'Mahen HA, Flynn HA. Preferences and perceived barriers to treatment for depression during the perinatal period. J Women's Heal. 2008;17(8):1301-1309.
57. Goodman JH. Women's attitudes, preferences, and perceived barriers to treatment for perinatal depression. Birth. 2009;36(1):60-69.
58. Bina R. Seeking help for postpartum depression in the Israeli

Jewish Orthodox Community: factors associated with use of professional and informal help. Women Heal. 2014;54(5):455-473.
59. Glasser S, Barell V. Depression scale for research in and identification of postpartum depression. Harefuah. 1999;136(10):764-768.
60. Simhi M, Sarid O, Cwikel J. Preferences for mental health treatment for post-partum depression among new mothers. Isr J Health Policy Res. 2019; 8: 84.
61. Scott S. Interpersonal psychotherapy for postpartum depression. Clinical psychology & psychotherapy. 2012; 19(2): 134-140.
62. Burt VK, Suri R, Altshuler L, Stowe Z, Hendrick VC, Muntean E. Am J Psychiatry. 2001; 158(7):1001-1009.
63. Misri S, Kostaras X. Benefits and risks to mother and infant of drug treatment for postnatal depression. Drug Saf. 2002; 25(13):903-911.
64. Weissman AM, Levy BT, Hartz AJ, Bentler S, Donohue M, Ellingrod VL, Wisner KL. Pooled analysis of antidepressant levels in lactating mothers, breast milk, and nursing infants. Am J Psychiatry. 2004; 161(6):1066-1078.
65. Boath E, Henshaw C. The treatment of postnatal depression: a comprehensive literature review. Journal of Reproductive and Infant Psychology. 2001;19(3):215-248.
66. Scaunasu R, Voiculescu Ștefan, Popescu B, Popa R, Bălălău D, Răducu L, Cozma CN, Jecan CR. Depression and breast cancer; postoperative shortterm implications. J Mind Med Sci. 2018;5(1):82-84.
67. van Schaik DJ, Klijn AF, van Hout HP, van Marwijk HW, Beekman AT, de Haan M, van Dyck R. Patients' preferences in the treatment of depressive disorder in primary care. Gen Hosp Psychiatry. 2004; 26(3):184-189.
68. Pearlstein TB, Zlotnick C, Battle CL, Stuart S, O'Hara MW, Price AB, Grause MA, Howard M. Patient choice of treatment for postpartum depression: a pilot study. Arch Womens Ment Health. 2006; 9(6):303-308.
69. Danciu R, Marina C, Ardeleanu V, Marin R, Scăunașu R, Răducu L. Breast implant illness: a step forward in understanding this complex entity and the impact of social media. J Mind Med Sci. 2019;6(2):351–355.
70. Stuart S, O'Hara MW. Interpersonal psychotherapy for postpartum depression: a treatment program. J Psychother Pract Res. 1995; 4(1):18-29.
71. Younggren JN, Harris EA. Can you keep secret? Confidentiality in psychotherapy. Journal of Clinical Psychology, 2008;64: 589-600.
72. Bennett BE, Bricklin PM, Harris E, Knapp S, Vandecreek L, Younggren JN. Principles of risk management: A patient-oriented approach.Washington, DC: APAIT, 2007.