Dealing with the patient with postnatal depression

PHILIP BOYCE MD, FRANZCP

Psychoeducation, non-directive counselling and psychological and pharmacological treatments may all be involved in managing this common disorder.

CORDELIA MOLLOY, SCIENCE PHOTO LIBRARY

Remember

- Postnatal depression is a common disorder, affecting 10 to 15% of women in the first six months after childbirth.
- It is frequently unrecognised and untreated, despite there being effective treatments for it.
- Postnatal depression is not a 'unique' type of depression; its symptoms are no different from the symptoms of depression occurring at other times in the life cycle, although there may be more anxiety symptoms than usually found in major depression, especially worry about the baby. Symptoms of panic commonly accompany postnatal depression, with some women reaching the threshold for panic disorder.
- Postnatal depression needs to be distinguished from 'the blues', which is a benign, transient condition that affects up to 70% of women, arises on the third to fifth day postpartum and remits spontaneously. It is important to remember that for some women the blues may herald the start of postnatal depression or puerperal psychosis. Postnatal depression needs to be distinguished also from puerperal psychosis, which is a severe psychotic disorder that affects one to two women in 1000 deliveries. Puerperal psychosis is considered a variant of bipolar disorder; it has its onset within the first three weeks postpartum, presents with psychotic symptoms and generally requires specialist psychiatric care.
- The causes of postnatal depression are predominantly psychosocial. The major risk factors are:
  - lack of social support
  - a poor quality intimate relationship
  - past psychopathology
  - adverse childhood experiences
  - a vulnerable (anxious, sensitive or worrying) personality style.

Recent stresses, especially a traumatic delivery, can also increase the risk of postnatal depression. Hormonal factors, in particular oestrogen sensitivity, may play a part in some cases of postnatal depression but there is little evidence to suggest that postnatal depression is a 'hormonal' disorder.

- Women who have a previous history of major depression or an anxiety disorder are at high risk of developing postnatal depression. Depression or anxiety may be present during pregnancy and will usually persist after delivery.
- Postnatal depression may, if untreated, lead to chronicity and continuing disruption to significant interpersonal relationships.
- The infants of women with postnatal depression may be impaired in their emotional and cognitive development. The children of women with postnatal depression have been shown to have emotional and cognitive difficulties by one year of age. This is likely to be the result of their mothers' lack of responsiveness to them in the first few months of life.
- Many women with postnatal depression do not seek treatment for their depression. They do not recognise that their unhappiness or difficulty in coping is due to depression; they believe it to be part of motherhood.
- Women often cover up their feelings of depression because they are ashamed to admit to feeling 'bad' at a time when they are expected to be happy. They often go out of their way to ensure they are well groomed and appear happy.
- Women may present to their general practitioner with problems with the baby as a 'ticket of entry' to talk about their postnatal depression. This is particularly so for frequent attendees, and postnatal depression should always be considered with these mothers.

Professor Boyce is Professor of Psychiatry, Discipline of Psychological Medicine, University of Sydney and Nepean Hospital, Penrith, NSW.

Edinburgh Postnatal Depression Scale (EPDS)[1]

Name: **Baby's age:**

As you have recently had a baby we would like to know how you are feeling. Please UNDERLINE the answer which comes closest to how you have felt IN THE PAST 7 DAYS, not just how you feel today. Here is an example already completed:

I have felt happy

A. Yes, all the time
B. Yes, most of the time
C. No, not very often
D. No, not at all

This would mean 'I have felt happy most of the time during the past week'.
Please complete the other questions in the same way.

In the past seven days:

1. **I have been able to laugh and see the funny side of things.**
   A. As much as I always could
   B. Not quite so much now
   C. Definitely not so much now
   D. Not at all
2. **I have looked forward with enjoyment to things.**
   A. As much as I ever did
   B. Rather less than I used to
   C. Definitely less than I used to
   D. Hardly at all
3. **I have blamed myself unnecessarily when things went wrong.**
   A. Yes, most of the time
   B. Yes, some of the time
   C. Not very often
   D. No, never
4. **I have been anxious or worried for no good reason.**
   A. No not at all
   B. Hardly ever
   C. Yes, sometimes
   D. Yes, very often
5. **I have felt scared or panicky for no very good reason.**
   A. Yes, quite a lot
   B. Yes, sometimes
   C. No, not much
   D. No, not at all
6. **Things have been getting on top of me.**
   A. Yes, most of the time I haven't been able to cope at all
   B. Yes, sometimes I haven't been coping as well as usual
   C. No, most of the time I have coped quite well
   D. No, I have been coping as well as ever
7. **I have been so unhappy that I have had difficulty sleeping.**
   A. Yes, most of the time
   B. Yes, sometimes
   C. Not very often
   D. No, not at all
8. **I have felt sad or miserable.**
   A. Yes, most of the time
   B. Yes, quite often
   C. Not very often
   D. No, not at all
9. **I have been so unhappy that I have been crying.**
   A. Yes, most of the time
   B. Yes, quite often
   C. Only occasionally
   D. No, not at all
10. **The thought of harming myself has occurred to me.**
    A. Yes, quite often
    B. Sometimes
    C. Hardly ever
    D. Never

Scoring of the EPDS

Each response is scored from 0 to 3 according to increased severity of symptoms. The total score is calculated by adding together the scores for each of the 10 items.

Assessment

- Always think about the possibility of postnatal depression in routine postnatal follow up visits (six-week check or vaccinations), which are ideal times to assess whether a woman is suffering from postnatal depression.
- The best way to identify postnatal depression is through a good clinical interview, which should involve:
  - asking the woman how she is feeling or how she is coping
  - allowing her time to be able to talk about her feelings without interruption
  - encouraging her to talk about any disappointment she may have in her new role as a mother, her feelings towards her baby or aspects about her current intimate relationship
  - asking about her delivery experience; women who have had a traumatic delivery or who have been disappointed in their delivery experience will benefit from talking about it.
- Check for the common symptoms of depression (loss of pleasure or interest in activities, low mood, lack of energy, sleep or appetite disturbance). Ask the woman specifically about her self-esteem, particularly about how she feels about herself as a mother and/or wife as that may be the main indicator that she is suffering from postnatal depression.
- Always check for suicidal ideation and for thoughts of harming the baby.
- It is important to distinguish depressive symptoms from those symptoms that might arise from being a new mother, such as tiredness, fatigue, weight loss, disturbed sleep and loss of libido. Check with the woman whether she thinks her fatigue is more than she had expected. Poor sleep because of worry about the infant is most likely to be due to postnatal depression.
- Ask the woman to complete the Edinburgh Postnatal Depression Scale, which is a very useful aid in identifying women with postnatal depression (see the box on this page).[1] This simple, user

friendly questionnaire is appropriate for use at six to eight weeks postnatally and can be completed by the woman in the surgery before a consultation or at a child health clinic. A score above 12 indicates a high probability that the woman may be suffering from postnatal depression; however, scores above 10 should raise the index of suspicion of an underlying depression or anxiety disorder.

- Ask about the level of her social support; this should include family and friends. Two forms of support are essential: practical support and emotional support. Enquire whether her partner provides her with practical support, by looking after the baby (e.g. changing nappies) and helping with household chores, and emotional support, especially listening to her concerns.
- Women who have experienced physical, sexual or emotional abuse have a very high risk of postnatal depression. Part of the assessment of the woman with postnatal depression should include sensitive questions about whether they have in the past, or are currently, experiencing abuse.
- Ask about anxiety symptoms in addition to depressive symptoms, in particular anxiety about dealing with the baby.
- Always check with the woman whether she has thoughts or feelings about harming herself or the baby. It is important to allow her to discuss any fears that she may have for the baby.

Management

The first and most crucial part of management is to identify whether the woman is suffering from postnatal depression. Letting her know that she is suffering from postnatal depression is an essential first step in management.

- Psychoeducation is important in the management of postnatal depression. Women need to be informed that:
  - postnatal depression is common and affects at least one in 10 women
  - it is not her fault
  - she can be helped; the outcome for women with postnatal depression is good.
- Nondirective counselling – allowing the woman to talk about her feelings in a nonjudgemental, nonthreatening way – is very helpful for many women. In addition to this, a first line of treatment should include:
  - giving the woman permission to discuss her disappointments with her new role, her frustration at not being able to do things that she used to be able to do and any feelings of resentment towards her infant
  - giving her permission to access social support networks and telling her it is alright for her mother to look after the baby or for neighbours to provide a meal; this should include telling her it is okay to ask for additional practical and emotional support
  - ensuring she has 'time-out' for herself, especially encouraging her to engage in pleasurable activities
  - encouraging her to prioritise her time so that she does not become preoccupied with conducting unnecessary activities
  - practical measures such as putting her in touch with organisations that can help her with any infant feeding or sleeping difficulties (such as the Nursing Mothers' Association) and with mothers groups where she can get some support; community services can be useful in providing some practical support.
- Psychological treatments have been shown to be effective for postnatal depression. They have the advantages that they can be tailored specifically to deal with the woman's problems and that breastfeeding can be continued without having to worry about any potential effects of medication passing through breast milk. They also have built-in relapse prevention strategies.
- If simple, nondirective counselling does not help, more extensive psychological treatments such as cognitive behavioural therapy and interpersonal therapy have been shown to be effective.
- Pharmacological treatment is appropriate and necessary for some women, such as those in whom:
  - the depression is moderate to severe in severity
  - the depression is not responding to nonpharmacological treatments
  - there is significant comorbidity, particularly with panic disorder.

Previous responses to antidepressant medication and patient preference are also important factors.

- Pharmacological treatment should be considered as an add-on to the essential nonpharmacological treatment.
- Antidepressant medication is the pharmacological treatment of choice. There is no evidence that one class of antidepressant is more effective than any other; the choice of antidepressant will depend upon safety to the infant if the woman is breastfeeding, safety for the mother (risk of overdose), tolerability and personal preference. The tricyclic antidepressants are safe for breastfeeding mothers, but their side effects and potential lethality in overdose should be considered. The SSRIs also appear to be safe for use with breastfeeding mothers, and are particularly effective for management of anxiety symptoms. If the SSRIs are used, it is important to remember that anxiety symptoms may initially be exacerbated.
- If there are concerns about the woman's capacity to look after her infant, or where there is risk of harm to the infant, the appropriate authorities need to be informed. MT

Reference

1. Cox JL, Holden JM, Sagovsky R. Detection of postnatal depression: development of the 10-item Edinburgh Postnatal Depression Scale. Br J Psychiatry 1987; 150: 782-876.