REVIEW ARTICLE

A Review On The Management Of Postnatal Depression

Shaheen Rahman Chowdhury[1], Rumana Nazneen[2], Sharifa Begum[3]

Postnatal depression (now often referred to as PND) means becoming depressed after having a baby. PND is one of the most common illnesses following childbearing. At least one in the ten women experiences depression in the weeks or months after the birth of a baby. While many recover spontaneously within a few months, one third to one half still have features of depression 6 months after delivery and some go on to develop a chronic or recurrent mood disorders [1,2]. If treated soon enough it can be nipped in the bud. Depression in the early postnatal months can have important effects on the mother and her baby and on other family relationships [1].

Background:

Emotional disturbances after childbirth are common, complex and can take many forms[4] Depressed mood is frequently a feature and two syndromes, in particular, are commonly described: so called 'maternity blues' and non-psychotic postnatal depression 'proper'. 'Maternity blues' affects 50-60 % of all newly developed women regardless of parity and therefore can be regarded as a normal part of the emotional changes after childbirth[5]. They are characterized by labile mood ('lows' and 'highs'), tearfulness, mild hypochondriasis, anxiety and irritability.The blues classically begins 3-5 days after delivery & generally resolves by the tenth day and do not require specific treatment [5].

The clinical importance lies in the need to offer reassurance to the mother and the family and to distinguish maternity blues from early-onset, more severe depression.The reported prevalence of non -psychotic post natal depression varies depending on the exact method of assessment used and the length of the post partum period studied. A meta-analysis of 59 studies found an overall prevalence of 13% [6].The incidence is highest in the first 3 months post partum & the pick time of onset is in the first 4-6 weeks[7]. Among primiparae who develop PND, around 30% develop further depression after a subsequent birth [2]. In a prospective study, the recurrence rate was higher among women in whom the first episode of PND represented the first ever depressive illness, compared with the rate in those with a back ground of earlier bouts of depression unrelated to childbirth (41% vs 18%)[2]. This suggest that there may be a population of women for whom the postpartum period is a specific, rather than a non- specific, risk factor for the development of depressive disorder.

Risk Factors:

The factors most strongly associated with postnatal depression are: a past history of psychiatric disorder (usually depression); mood disorder during pregnancy; a poor marital relationship & lack of social support; & recent stressful life events (eg: bereavement or illness)[6]. low social status, birth complications are weaker predictors. Severe maternity blues, or irritability or poor motor control in the baby, seem to increase risk[8]. Concentration of progesterone in the blood falls by a factor of about 1,000 in the days after childbirth. The level of oestrogen also falls, but less so. These changes may have an affect on mood[9]. The presence of thyroid microsomal antibodies in the blood (found in about 12% of women of child bearing age) is associated with a slightly increased risk of developing PND [10]. The mechanism appears to be unrelated to whether there is clinical or biochemical evidence of thyroid dysfunction [10].

1. Assoc. Prof. of Obs. & Gynae, HFRCMCH
2 Registrar,Dept. of Obs. & Gynae, HFRCMCH
3. Professor of Obs & Gynae, HFRCMCH

Clinical features:

While PND resembles depression occurring at other times, biological features of depression may be difficult to distinguish from the normal physiological & life changes associated with childbirth, including lowered energy, disturbed sleep, changes in appetite & diminish libido. Other depressive symptoms such as low mood, loss of enjoyment, lack of interest, tear fullness and impaired concentration are more helpful in guiding diagnosis. These symptoms may be accompanied by thoughts of self harm or suicide. The low mood & lack of emotional warmth often exacerbate feeling of guilt and failure in terms of looking after the baby [11]. Repetitive and Intrusive thoughts of harming the baby are quite common[4], being reported by 41% of postnatal depressed women in our study compared with 7% of non depressed mother [12].

Detection and diagnosis:

Early detection requires awareness on the part of all those nearest to the mother; in the first instance it may be a partner, family member or friend who simply notices that something is wrong. Health care professionals looking after the mother and baby also need to be alert to the mother's emotional state. The Edinburgh Postnatal Depression Scale (EPDS) [13] is a screening instrument which improves identification in the community of women who may have postnatal depression[14,15]. The 10-Item-self report questionnaire is easy to complete and acceptable to women who may not regard themselves as unwell or in need of medical intervention[13]. A score of 11-12 on the EPDS (out of maximum of 30) has a sensitivity of 76.7 % for detection of PND and a specificity of 92.5% [16]. Confirmation of PND requires a clinical interview (to assess mother's mood, elucidate depressive symptoms and suicidal thoughts and explore her feelings for and attachment to the baby) along with EPDS.

General care and prevention:

Education about PND is important for all those looking after the woman during her pregnancy and in the weeks after delivery. It is especially crucial that women and their partners and family members are aware of the condition and know what to look out for.

Antenatal care Health professionals should create a trusting relationship and identify any risk factors that could increase the mother's chances of developing PND. They should be aware of women who are socially isolated or who lack a supportive relationship with a partner, for whom additional social and psychological support and links with other mothers might be helpful in building up support networks for when the baby is born.

Depression During The Pregnancy:

Requires treatment.If an antidepressant is given, the choice of treatment will need to take into account the safety of the drug in pregnancy, as well as its effectiveness and how able the woman is to tolerate any unwanted effects.
Tricyclic Antidepressants (TCAs), Selective Serotonine reuptake inhibitors (SSRIs) have been used for many years. Neither TCAs nor SSRIs have been shown to cause congenital abnormalities[17], or neurobehavioral effects in children exposed to the drugs during pregnancy[18]. Various forms of brief psychotherapy, interpersonal therapy, have proven efficacy in the treatment of mild to moderate depression.

Support during labour and childbirth is very important and there is evidence that having a supportive companion during labour, even someone unknown to the mother, can protect against anxiety and depression in the subsequent weeks[19].

Treatment of pnd:

General measures If PND is diagnosed welfare of the mother, the baby and other children is paramount. The partner and family need help in understanding the mother's need for emotional support, rest, and practical help with the baby.

Specific Psychological interventions Three small randomized controlled trials have instigated the short term effectiveness of brief, community based psychological counseling compared to routine care [20], and compared with Anti depressant therapy. In these studies, 30- 60 minute counseling sessions were delivered by trained health visitors or nurses. In the first study 69% of women in the counseling group were deemed to have recovered compared with 38% of the control group[20]. In 2nd study 80% women recovered fully with counseling compared with 25% in the control group[21]. In 3rd study- Antidepressant or Placebo, plus either one or six sessions of counseling [22] were compared. All groups had improved but benefit was greater with antidepressant than placebo and with six sessions versus one session counseling. Referral to psychologist is essential for severely depressed mother.

Place of Antidepressants Antidepressants have been used for some time & a recent important review reports that SSRIs family of depressants is effective in treating PND. All antidepressants are secreted in the breast milk but the limited available data suggested that plasma concentration of TCAs and SSRIs in breast fed infants are rarely detectable on standard assays[23]. The baby should however be carefully watched for possible unwanted effects.

Hormone Therapy

Although widely used, there is no convincing evidence that progestogens are effective for treatment of (or prevention of) PND[24]. Oestrogens may help some women with PND[24,25] but such treatment is still experimental. Oestrogen therapy also has important drawbacks in terms of developing DVT (deep vein thrombosis) and is contraindicated in breast feeding women.

Conclusion

Postnatal depression is not an uncommon problem after child birth. While it usually resolves within a few months, it is occasionally followed by chronic mood disorder and may sometimes adversely affect the emotional and cognitive development of the child. Diagnosis of PND requires a high level of awareness in the health professionals. Brief psychological therapy or antidepressant drug therapy or combination of both are effective treatment. Very rarely a woman need specialist mental health services.

References

1. Kumar R, Robson KM: A prospective study of emotional disorders in childbearing women.Br J. Psychiatry 1984;144:35-47.
2. Cooper PJ, Murray h. Course and recurrence of postnatal depression. Evidence for specificity of the diagnostic concept. Br. J. Psychiatry. 1995; 166:191-5.
3. Cooper PJ, Murray h. The Impact of Psychological treatments of post partum depression on maternal mood and infant development. New York: Guilford Press, 1997; 201-20.
4. Brokinton I. Puerperal disorders. Adv. Psychiatric Treatment. 1998; 4: 312-9.
5. Kenerley H, Gath D. Maternity Blues. Detection and measurement by Questionnaire. Br. J. Psychiatry 1989; 155: 356-62.

6. O' Hara MW, Swain AM. Rates & risk of post partum depression – a meta analysis. Int. Rev. Psychiatry 1996; 8:35-54.
7. Cox JL, Murrey D, Chapman G. A controlled study of the onset, duration & prevalence of post natal depression. Br. J. Psychiatry 1993; 163: 27-31.
8. Murray L, Stanley C, Hooper R, King F, Flori-Cowley A. The role of infant factors in post natal depression & mother- infant interactions. Dev. Med. Child neurol 1996; 38: 109-19.
9. Harris B, Lovett L, Smith J, Read G, Walker R, New Combe R. Cardiff puerperal mood and hormone study. III. Post natal depression at 5 to 6 weeks post partum & its hormonal correlates across the peri partum period. Br. J. Psychiatry 1996; 168: 739-44.
10. Harris B, Othman S, Davis JA et al. Association between postpartum thyroid dysfunction and thyroid antibodies and depression . BMJ 1992; 305 : 152-6.
11. Kumar RC, " Any body's child". severe disorders of mother- to- infant bonding. Br. J. Psychiatry 1997; 171: 175-81.
12. Jennings KD, Ross S, Popper S, Elmore M. Thoughts of harming infants in depressed and non depressed mothers. J. Affect Disorder 1999; 54: 21-8.
13. Cox JL, Holden JM, Sagovsky R. Detection of post natal depression. Development of the 10 –Item Edinburgh Postnatal depression Scale. Br. J Psychiatry 1987; 150:782-6.
14. Seeley S, Murray L, Cooper PJ. The outcomes of mothers & babies of health visitor intervention. Health visit 1996; 69: 135-8.
15. Heam G, Lifa Jones I et al. Postnatal depression in the community. Br. J. Gen . Practice 1998; 48: 1064-6.
16. Murray L, Carothers AD,. The validation of the Edinburgh Postnatal Depression Scale on a community sample. Br. J. Psychiatry 1990; 157:288-90.
17. Cohen LS, Rosenbaum JF. Psychotropic Drug use during pregnancy: Weighing the risks. J. Clin. Psychiatry 1998; 59: 18-28.
18. Nulman I, Rovet J, Stewart DE et al. Neuro development of Children exposed in utero to Anti Depressant Drugs. N. Engl. J. Med.1997; 336: 258-62.
19. Wolman WL, Chalmers B, Hofmayer GJ, Nikodem VC. Postpartum depression & Companionship in the clinical birth environment: A randomized, controlled study. Am J. Obstet Gynaecol 1993; 168: 1388-93.
20. Holden JM, Sagovsky R, Cox JL. Counseling in the general practice setting: Controlled study of health visitor Intervention in treatment of Postnatal depression. BMJ1989; 298:223-6.
21. Wickberg B, Hwang CP. Counselling of postnatal depression: A controlled study on a population based Swidish sample. J Affect. Disord.1996;39:209-16.
22. Appleby L, Warner R , Whitton A, Faraghar B. A controlled study of Fluoxetine and cognitive behavioral counseling in the treatment of postnatal depression. BMJ. 1997; 314: 932-6.
23. Yoshida K, Smith B, Kumar R. Psychotropic Drugs in mother's milk. A comprehensive review of assay methods, Pharmacokinetics and of safety of breast feeding. J. Psychopharmacol 1999; 13: 64-80.
24. Lawrie TA, Herxheimer A, Dalton K. Oestrogen & Progestogens for preventing and treating postnatal depression (Cochrane Review) The Cochrane Library,Issue 2, 2000.
25. Gregoire AJP,Kumar R, Everitt B, Henderson AF, Studd JWW. Transdermal Oestrogen for treatment of severe postnatal depression. Lancet 1996; 347:930-3.