Postnatal Depression

Both the National Institute for Health and Care Excellence (NICE) and the Scottish Intercollegiate Guidelines Network (SIGN) have released guidance on the management of mental health conditions in the perinatal period. [1, 2]

SIGN defines postnatal depression (PND) as "any non-psychotic depressive illness occurring during the first postnatal year". [2] The term "postnatal depression" should not be used as an umbrella term for all mental health problems following delivery. It is one of a number of under-recognised mental health problems which may occur in the postnatal period, others including a range of anxiety disorders, such as generalised anxiety disorder, obsessive-compulsive disorder, panic disorder, phobias, posttraumatic stress disorder and social anxiety disorder. [1]

Depression can occur de novo, can be a recurrence of a depressive condition occurring prior to pregnancy, or be part of a wider problem - eg, bipolar disorder. Assessment and management are much like that of depression at any other time, the key differences being the implications of the illness and its management for the baby, and the risk of postpartum psychosis.

Epidemiology [2, 3]

Depression in itself is common, and the overall prevalence of PND is probably not significantly more common than at other times. It may be that it is more common in the first few weeks postnatally than at other times. [4] Meta-analyses of studies mainly based in the developed world found the prevalence of PND to be around 10-15%. Higher rates are found when self-reported questionnaires are used than when structured clinical interviews are performed, and higher rates occur in developing countries. [5]

Possibly as few as 15% of women with symptoms of PND seek or obtain medical advice. [6]

Aetiology [2, 7]

There is no convincing evidence that hormonal changes cause PND.

The strongest risk factors appear to be:

- Previous history of mental health problems.
- Psychological disturbance during pregnancy.
- Poor social support.
- Poor relationship with partner.
- Baby blues.
- Recent major life events.

Other risk factors include:

- Unplanned pregnancy.
- Unemployment.
- Not breast-feeding.
- Antenatal parental stress.
- Antenatal thyroid dysfunction.
- Longer time to conception.
- Depression in the father of the child.
- Having two or more children.
- Current, or history of, substance misuse.
Weak associations have also been found for:

- Obstetric complications.
- History of abuse.
- Low family income.
- Lower occupational status.

Presentation

PND presents with the same symptoms as those of depression in other circumstances. However, take into account that some of the symptoms associated with depression can be normal in the early postnatal period (sleep disturbance, tiredness, anxiety about the baby). Symptoms of depression include: [7, 8]

- Low mood.
- Loss of enjoyment and pleasure.
- Anxiety.
- Disturbed sleep.
- Loss of appetite.
- Poor concentration.
- Low self-esteem. Worthlessness and inappropriate feelings of guilt.
- Low energy levels.
- Loss of libido.
- Thoughts of death/suicidal thoughts

NICE warns that health professionals should be aware that women may be unwilling to disclose symptoms of depression and other mental health problems or reluctant to engage. [1] This may be due to fear of stigma, fear the baby may be taken into care, concern that they will be perceived as a poor mother, the nature of the condition or problems with alcohol or substance dependence.

Diagnosis [1]

At booking and at postnatal checks, all health professionals should consider mental health screening questions. First, consider asking the following two questions to screen for depression:

- During the past month, have you often been bothered by feeling down, depressed or hopeless?
- During the past month, have you often been bothered by having little interest or pleasure in doing things?

Second, consider asking the following two questions about anxiety:

- During the past month have you been feeling nervous, anxious, or on edge?
- During the past month have you not been able to stop or control worrying?

If the answer is "yes" to any of these questions, or if there is clinical concern, further assessment is required. This may be by the use of a formal assessment tool, such as the Patient Health Questionnaire (PHQ-9), the Edinburgh Postnatal Depression Scale or the Generalised Anxiety Disorder Scale (GAD-7).

Assessment

NICE advises that assessment of any mental health problem in either pregnancy or the postnatal period should include the following: [1]

- Past history or family history of any mental health problem. Also any current or past treatment for a mental health problem and response to any treatment.
- Physical well-being and history of any physical health problem.
- Alcohol and drug misuse.
• The woman's attitude to and experience of the pregnancy.
• The mother-baby relationship.
• Relationships and social networks.
• Living conditions and social isolation.
• Domestic violence and abuse, sexual abuse, trauma, or childhood maltreatment.
• Housing, employment, and economic and immigration status.
• Responsibilities as a carer for other children and young people or other adults.

Management[1, 2]

General principles

• **Empowerment.** Involve women in decisions about their care. Partners, family and carers should also be involved, if the woman agrees. Reassure the woman that postnatal depression is not uncommon, and be optimistic about its resolution. Give her all the information she needs to make informed decisions about treatment, and acknowledge her central role in the decision-making process. Ensure adequate contact and support networks. For patients who lack capacity, follow the Department of Health guidelines and the code of practice accompanying the Mental Capacity Act.

• **Communication.** Good communication is important - the woman, her relatives and carers should be given information in a form that is culturally appropriate and takes account of any physical disabilities that present an obstacle to comprehension (eg, deafness). Communication between all health professionals involved is vital for integrated care. Develop an integrated care plan.

• **The wider family environment.** Consider the needs of other children, dependent adults, and the effect the illness may have on relationships with partners. The welfare of the baby must always be born in mind.

• **Adolescents.** Bear in mind local and national guidelines concerning confidentiality and the rights of the child. When obtaining consent, issues that may need to be considered include Gillick competence, child protection concerns, current mental health legislation, and the Children Act.

Management strategy

SIGN guidelines advise that the choice of treatment for postnatal depression should be governed by efficacy, previous response to treatment, incidence of side-effects, likely compliance, patient preference and, in the case of pharmacological therapies, safety during breast-feeding. NICE guidelines suggest the following strategy.

Mild to moderate depression

Consider facilitated self-help strategies (as per NICE guidelines on depression).[9]

Mild depression with a history of severe depression

Consider an antidepressant.

Moderate or severe depression

Consider:

• High-intensity psychological intervention such as cognitive behavioural therapy (CBT).
• Antidepressant treatment if:
  • Risks are understood and accepted, particularly if breast-feeding.
  • The woman declines psychological therapy.
  • Psychological therapies have failed.

• High-intensity psychological intervention in combination with antidepressant therapy.

Psychological treatments

• There is evidence that psychological therapies are of benefit. Evidence is strongest for CBT and interpersonal psychotherapy.[10]
• NICE guidelines advise psychological therapies are first-line consideration in most cases as per the section above.
• Facilitated self-help strategies are described in NICE depression guidelines and are based on the principles of CBT. They should be supported by a trained practitioner, over a 9- to 12-week period, either face-to-face or by telephone.
High-intensity psychological treatments such as CBT or interpersonal psychotherapy must be delivered by appropriately trained practitioners. Psychological treatments should be provided promptly (within one month at most, and assessment should take place within two weeks of referral).

Pharmacological therapy
Unfortunately, evidence remains unclear about the role and safety of antidepressants in breast-feeding women, so guidelines are unable to give clear direction. Clinicians and women with PND have to base their decisions on an individual basis, taking into account all risks and benefits and the information available about potential harm to the baby. A Cochrane review concluded there was not sufficient evidence to make recommendations about the efficacy of antidepressants in this situation, to compare them to psychological therapies or each other, or to determine which was safest for the baby.[11]

NICE guidelines recommend women be encouraged to breast-feed, unless they are taking lithium, sodium valproate, carbamazepine or clozapine. However, they should be supported in whichever method of feeding they decide upon. There should be a higher threshold for pharmacological therapy in the treatment of depression during pregnancy and the postnatal period than at other times, due to the change in risk:benefit ratio. Clinicians should take into account the limited safety data available on each antidepressant when prescribing for breast-feeding women, fully inform the woman of potential risks, and monitor the baby for adverse effects. A tricyclic antidepressant (TCA), selective serotonin reuptake inhibitor (SSRI) or serotonin-noradrenaline reuptake inhibitor (SNRI) may be considered. 2014 NICE guidelines make no recommendations other than to consult the safety information of each individual drug. 2012 SIGN guidelines suggest that the TCAs imipramine and nortriptyline and the SSRIs sertraline and paroxetine are present in breast milk at relatively low levels. They further recommend that fluoxetine, citalopram and escitalopram should be avoided if initiating antidepressant medication at this time, due to comparatively higher levels being present in breast milk, and doxepin avoided altogether. These recommendations were based on a 2009 meta-analysis, thus pre-dating the latest Cochrane review which was unable to make any recommendation.[12]

There is no place for synthetic progestogens in the treatment of PND.[13] There may be a modest role for oestrogens in the treatment of severe postpartum depression, but further research is required.

Issues to consider and discuss in choosing treatment[1, 6]
- The current uncertainty about the benefits, risks and harms of treatments for mental health problems in pregnancy and the postnatal period.
- The likely benefits and risks of each treatment, taking into account the severity of depression.
- Benefits of breast-feeding.
- Potential benefit of antidepressant drugs and the impact of relapse and recurrence if the drugs are stopped. Potential risk of harm to mother and baby if depression is not treated.
- Evidence of response to a particular antidepressant for that individual woman.
- For a mother who is successfully treated for depression during pregnancy, it might be better to continue the same antidepressant postpartum because stopping or switching the drug might lead to relapse.
- Maternal side-effects of drugs - sedation might affect a mother's ability to care for the child, particularly at night.

Management of severe depression
Women who have ideas of either suicide or of harming the baby, should be referred immediately for urgent psychiatric assessment. Child protection procedures may need to be invoked.

A few mothers have depression that is too severe to be managed solely in primary care and will require the involvement of a psychiatrist; sometimes needing compulsory admission using the Mental Health Act. Dedicated "mother and baby units" offer the ideal environment but are not available in all areas. Care needs to be delivered and monitored by a multidisciplinary team linking closely with social services and family mental health services.

Prognosis
The course of the illness is widely variable and will depend on predisposing factors and response to treatment. PND is associated with reduced likelihood of mother-baby bonding and impaired cognitive function in the child.
Most cases resolve within 3-6 months, but a quarter of affected women still have symptoms a year later.[6]

Whilst women are at generally low risk of suicide during pregnancy, it is a significant cause of maternal death in the year following birth in the UK.[14] Improving awareness of perinatal mental health problems, in all their diversity, is important.

Complications[7]

When PND is untreated it is associated with adverse effects on the infant. These effects are both short-term and long-term poorer cognitive, emotional, social and behavioural development.[15] Negative influences of mothers’ depression are seen in their language skills and intelligence quotients (particularly in boys). However, these effects are not universal. It is only seen when the mother is unable to engage actively with the infant.

Postpartum psychosis[6]

Postpartum (or puerperal) psychosis is more often associated with bipolar disorder or with schizophrenia, but may occur with severe depression. 1 in 1,000 women are said to develop postpartum psychosis after childbirth. It usually occurs in the first few weeks after childbirth, and is significantly common in women who have a past history or family history of postpartum psychosis. It may be associated with depressive, manic or mixed symptoms of mood disorder, along with psychotic features. These can include paranoia, delusions, hallucinations, loss of inhibition, agitation and loss of contact with reality. It is a psychiatric emergency and usually requires admission to a specialist mother and baby unit, and mood-stabilising and antipsychotic medication.

Prevention[1]

NICE recommends that women be proactively screened for mental health problems and high-risk patients identified. It is advised that when women present for booking and at the postnatal check, health professionals (including midwives, obstetricians, health visitors and GPs) should ask questions to screen for depression and anxiety (as in the ‘Diagnosis’ section, above). At the first contact they should also ask about:

- Past or present severe mental illness including schizophrenia, bipolar disorder, psychosis in the postnatal period and severe depression.
- Previous treatment by a psychiatrist/specialist mental health team including inpatient care.
- A family history of severe perinatal mental illness in a first-degree relative.

SIGN recommends that enquiry about depressive symptoms should be made (as the minimum) on booking and postnatally at 4-6 weeks and 3-4 months.[2]

Women identified as at high risk of developing severe depression, or with a history of severe mental illness, should be referred to secondary care mental health services.

Further reading & references

1. Antenatal and postnatal mental health: clinical management and service guidance; NICE Clinical Guideline (December 2014)
2. Management of perinatal mood disorders; Scottish Intercollegiate Guidelines Network - SIGN (March 2012)
7. Depression - antenatal and postnatal; NICE CKS, January 2013 (UK access only)
8. Depression; NICE CKS, August 2013 (UK access only)

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