

# Clinical Focus

## Continuing education and moving points in medicine

In this section: Brain disease (below), child health page 55

### Continuing Education Module 20: Brain disease

## Postnatal depression: risk factors, assessment, identification and treatment

**Patricia Leahy-Warren** discusses emotional maternal health in the postpartum period, including symptoms and evidence-based treatments and their outcomes

THE World Health Organisation-United Nations Population Fund has clearly identified maternal mental health as fundamental in attaining the 'Millennium Development' goals. Maternal mental health has also been identified as a priority within the 'Vision for Change' mental health strategy document in Ireland. Becoming a mother is a major developmental transition of adulthood and this transition is a process of personal and interpersonal change that occurs as a woman assumes maternal tasks and appraises herself as a mother. Becoming a mother, although a joyous occasion in most instances, for some women it can be a stressful or distressing time.

More than one in 10 (13%) women experience postnatal depression (PND) during the first year postpartum with most cases commencing in the first three months.<sup>1,2</sup> It occurs at a crucial time in a mothers' life and can persist for long periods. It can have adverse effects on partners, and on the emotional and cognitive development of infants and children.

For many women, the period following delivery is one of increased psychological vulnerability, detectable across a broad spectrum of reactions. If left untreated, PND can have detrimental consequences for the mother, infant and family, and can progress into severe clinical depression which can be a precipitating factor to suicide, which is the second-most-frequent cause of maternal death in Ireland and the leading cause in the UK and infanticide in some severely depressed mothers.<sup>3</sup> There are a number of postnatal emotional disorders, which may include some similar symptoms, but are distinguishable from PND.

Emotional disorders in the postpartum are described and differentiations are made between them and depression in the postnatal period. This is followed by an outline of the symptoms of PND as experienced by mothers. Knowledge of risk factors and screening for PND are crucial steps in dealing with this significant problem for new mothers.

Finally, the treatments for PND are outlined, including the benefits of social support and supportive home visits by public health nurses.

#### Emotional disorders in the postpartum period

Women are vulnerable to anxiety and depression throughout the perinatal period, including the early postnatal period and up to the first year post delivery. There are a number of postnatal



emotional disorders which may include some similar symptoms but are distinguishable from postnatal depression.

'Maternal blues' is the name given to the rapid fluctuations in mood experienced by 50-70% of all mothers and is generally regarded as a normal response to childbirth. It is usually a short-lasting episode occurring sometime between the third and fifth or 10th day postpartum. Brockington argues that the postnatal blues is a trivial disorder, which is simply the ending of postnatal euphoria and akin to premenstrual tension, the main symptom of which is irritability.<sup>4</sup> However, while postnatal blues are regarded

as brief, benign and without clinical significance, the significance is the proposed link between blues and subsequent postnatal depression as evidenced by research.<sup>4</sup>

Post traumatic stress disorder (PTSD) is an anxiety disorder related to exposure to a traumatic event such as childbirth. Research shows that negative birth outcomes as perceived by mothers and normal delivery outcomes as perceived by the healthcare staff, may lead to psychological distress such as PTSD. Some studies have found similarities between symptoms of PTSD and PND and thus comorbidity may exist. However, they are not mutually exclusive and may occur in the absence of one another.

Postpartum panic attacks are characterised by symptoms such as palpitations, chest pain, and shortness of breath, numbness and fear of losing control. Mothers described feelings of being paralysed and out of control; inability to think during the attack; struggle to maintain composure leading to exhaustion; lowering of self-esteem; and bearing the burden of disappointing themselves and their families.

Mothers also fear losing control during a panic episode and not being able to care for their infant during this time. One study found that episodes can occur around seven weeks postpartum.<sup>5</sup> There is a paucity of research exploring the relationship between panic disorder and PND. Nevertheless, cognisance needs to be taken of the evidence that in the general population half of those individuals with panic disorder also have depression, which will also impact on women in the postnatal period.

Postpartum psychosis is the most serious postpartum emotional disorder and is associated with high rates of suicide and infanticide.<sup>6</sup> Postnatal psychosis occurs in one to two cases per 1,000 births and can include clinical signs such as hallucinations, delusions, agitation, inability to sleep, and bizarre, irrational behaviour. Unlike other postnatal emotional disorders, postnatal psychosis may also include symptoms of postnatal depression.

The report of the Centre for Maternal and Child Enquiries<sup>3</sup> (CMACE) reported suicide as the most common cause of maternal death for women in the first year after childbirth. Postnatal depression falls between the blues and postnatal psychosis in symptoms of severity and is characterised by tearfulness, despondency and excessive anxiety over the baby.

### **Risk factors and assessment**

The prevalence of depression in the first postnatal year ranges from 10-25% with a rate of 13% indicating a serious public health issue.<sup>7</sup> The adverse effects of PND on partners, the emotional and cognitive development of infants and children are well documented. Maternal depression may also affect infants' attachment to their mothers and depressed mothers are more likely to report stress, have hostile feelings towards their infant, and have negative perceptions of their infants' behaviour.<sup>8</sup>

The strongest predictors of PND are related to antenatal anxiety, previous history of depression, lack of social support, particularly partner support and stressful life events.<sup>9</sup>

Depression can be classified as mild, moderate and severe. Within the diagnostic guidelines depression includes at least a two-week period of depressed mood, loss of interest and enjoyment, and increased fatigability. In making a definitive diagnosis of depression, at least two of these symptoms plus at least two others, such as reduced energy, changes in appetite, pessimism, low self-esteem, sleep disturbance, ideas of guilt, suicidal

thoughts, must be present. Mothers' own descriptions of postnatal depression include an element of loss, such as loss of control or loss of former identity.<sup>10</sup>

Research reported that mothers express feelings of inadequacy and inability to cope particularly with the baby, unusual irritability, impaired concentration and memory loss. Also, undue fatigue and ready exhaustion with sleep disturbances over and above the inevitable with a new baby were found. Mothers' comments reflect the exhaustion and indecision they experienced that affected their confidence in their infant care taking skills: "I didn't even want to get out of bed but my family expected me to get up, so I did. But it was an effort, too much hard work."

Another mother, describing her distress, said: "I just couldn't remember what I was supposed to do. What did he need? I couldn't believe that this is what it would be like all day. I just couldn't do it. I couldn't be alone. I was afraid that things would go wrong!"<sup>11</sup>

Findings reflect mothers' difficulties with infant care taking and their delay in adapting to motherhood. Consequently, postnatal depression differs from general depression, not only in relation to the timeframe, but also in the context of role transition, which includes loss of familiarity and thus loss of control and the need to feel normal. The rich data obtained from qualitative studies provides an understanding for nurses of what it is like for mothers living with postnatal depression.

Public health nurses (PHN) provide routine care to all new mothers in the community, and are ideally placed to screen for PND and provide support. However, current PHN practice differs considerably due to the variation of individual PHNs' knowledge, skills, expertise, and confidence in screening for PND. Furthermore, a recent national review of PHN practice indicated that in many areas curative care takes precedence to maternal and child health.<sup>12</sup>

In a study with first-time mothers, the greatest predictor at 12 weeks for increased risk of PND was low healthcare professional support at birth, and low appraisal support at 12 weeks.<sup>13,14</sup> In a previous study with postnatal first-time mothers (n=99) participants reported that PHNs were the healthcare professionals that provided them with appraisal support, suggesting the importance of this type of support for mothers in the postnatal period.<sup>15</sup>

### **Identification and treatment**

Despite its relatively high incidence, postnatal depression can be difficult to detect, in part because new mothers are often reluctant to report depressive symptoms to healthcare professionals. The most significant factor in the duration of postnatal depression has been found to be the length of delay to early recognition and adequate treatment.<sup>16</sup>

There are recommendations about the management of PND within the National Institute for Health and Clinical Excellence (NICE)<sup>17</sup> but currently there is no national policy on screening for PND. Screening new mothers for identification of risk can be done using the Whooley<sup>18</sup> questions in conjunction with the Edinburgh Postnatal Depression Scale (EPDS)<sup>19</sup> as recommended by the NICE 45 guidelines.<sup>17</sup>

Subsequent to the verbal screen questions (ie. the Whooley questions) it is found that the EPDS is a useful tool as an aid to improve detection of postnatal depression. It also helps to

allow women to think about their feelings and moods, even if they are not clinically depressed. The EPDS scale is a self-report questionnaire that has been developed for use by health professionals to assist in the detection of postnatal depression. It is a rating questionnaire providing a measure of the frequency of some symptoms relating to depressed mood and anxiety, and as such can be used to review progress over time. The EPDS is used to assess for risk of depression and is not a diagnostic tool.

Treatment options for mothers with postnatal depression require consideration of severity of depression, and preferences of the mother. Evidence-based treatments include antidepressants, cognitive behavioural counselling (CBC), cognitive behavioural therapy (CBT), and supportive counselling, either in the home, as a member of a group or telephone contact. Combined approaches involving psychopharmacology and psychotherapy using a holistic approach with mothers have been demonstrated to be effective.<sup>7</sup>

Social support can facilitate women's transition to motherhood as some mothers find it psychologically stressful. Research has shown that social support from partners, maternal mothers, peers and home visits from nurses have reduced postnatal depressive symptoms. Within the Irish context, Leahy-Warren et al found that appraisal support, which is receiving positive affirmation with caring for their infant, had a significant influence in their confidence in caring for their infants and reduced risk of PND.<sup>13,14</sup>

Mothers' revealed that the sources of this type of support were their partners, own mothers and healthcare professionals caring for mothers in the postnatal period. A number of studies reported that intervention by PHNs, which included both assessment and supportive counselling sessions, found a significant decrease in mothers' depression scores compared to the usual care group, thus indicating that support from the PHN may have a preventive effect on PND in women.<sup>2,20,21</sup> However, there have been no Irish trials of one-to-one intervention of PHNs for PND based in routine primary care.

There is a need for a clinical trial to examine the feasibility of this one-to-one intervention in the Irish context to ascertain both clinical effectiveness and cost efficiency from a health service perspective in addressing this serious public health issue.

## Conclusion

Emotional disorders in the postpartum period are all too prevalent and thus a serious public health issue. Left undetected it can have devastating consequences for mothers, partners, infants and their families. Early identification and screening for PND are crucial steps in dealing with this significant problem for new mothers.

It is essential that nurses facilitate the identification of individual mothers' sources of support and to help them to mobilise support from within their social network. Effective treatments for PND are available including the benefits of social support and supportive home visits by PHNs, which requires further research using robust methodologies in the Irish context.

**Patricia Leahy-Warren PhD is a senior lecturer in nursing and midwifery at the School of Nursing and Midwifery, University College Cork**

## References

1. Leahy-Warren P, McCarthy G, Corcoran P. Postnatal Depression in First-Time Mothers: Prevalence and Relationships between Functional and Structural Social Support at 6 and 12 Weeks Postpartum. *Archives of Psychiatric Nursing* 2011; 25 (3): 174-184



doi:10.1016/j.apnu.2010.08.005

2. Morrell CJ, Slade P, Warner R, Paley G, Dixon S, Walters SJ, Brugha T, Barkham M, Parry GJ, Nicholl J. Clinical effectiveness of health visitor training in psychologically informed approaches for depression in postnatal women: pragmatic cluster randomized trial in primary care. *British Medical Journal* 2009; 338: a3045
3. CMACE UK 2011 Saving Mothers' Lives Reviewing maternal deaths to make motherhood safer: 2006-2008 <http://www.centreformidwiferyeducation.ie/wp-content/uploads/2011/03/CMACE-2011-Saving-Mothers-Lives-Reviewing-maternal-deaths-to-make-motherhood-safer-2006-2008.pdf> (accessed 20/09/2012)
4. Brockington I. *Motherhood and Mental Illness*. 1996, Oxford: Oxford University Press
5. Beck CT. Post-Traumatic Stress Disorder Due to Childbirth: The Aftermath. *Nurs Res* 2004; 53(4): 216-224
6. Appleby L, Mortensen P, Faragher E. Suicide and other causes of mortality after post-partum psychiatric admission. *Br J Psychiatry* 1998; 173: 209-211
7. Leahy-Warren P & McCarthy G. Postnatal depression: Prevalence, Mothers' perspectives, and treatments. *Archives of Psychiatric Nursing* 2007; 21(2): 91-100
8. Field T. Postpartum depression effects on early interactions, parenting, and safety practices: A review. *Infant Behavior and Development* 2009 doi:10.1016/j.infbeh.2009.10.005
9. Milgrom J, Gemmill A, Bilszta J, Hayes B, Barnett B, Brooks J, Ericksen J, Ellwood D, Buist A. Antenatal risk factors for postnatal depression: A large prospective study *Journal of Affective Disorders* 2008; 108: 147-157. doi:10.1016/j.jad.2007.10.014
10. Nicolson P. Understanding postnatal depression: a mother-centred approach. *Journal of Advanced Nursing* 1990; 15: 689-695
11. Barr J. Postpartum depression, delayed maternal adaptation, and mechanical infant caring: a phenomenological hermeneutic study. *International Journal of Nursing Studies* 2008; 45(3): 362-369
12. Office of the Nursing and Midwifery Services Director PHN Services Review Report on Current Public Health Nursing Services 2012, Dublin, ONMSD
13. Leahy-Warren P, McCarthy G, et al. First-Time Mothers: Social Support, Maternal Parental Self-Efficacy and Postnatal Depression. *Journal of Clinical Nursing* 2012; 21(3-4): 388-397
14. Leahy-Warren P, McCarthy G, Corcoran P. Postnatal Depression in First-Time Mothers: Prevalence and Relationships between Functional and Structural Social Support at 6 and 12 Weeks Postpartum. *Archives of Psychiatric Nursing* 2011; 25(3): 174-184
15. Leahy Warren P. First-time mothers: social support and confidence in infant care. *Journal of Advanced Nursing* 2005; 50(5): 479-488
16. Beck C. Postpartum depression: it isn't just the blues. *American Journal of Nursing* 2006; 106(5): 40-50
17. National Institute for Health and Clinical Excellence Antenatal and postnatal mental health: clinical management and service guidance (No. 45) (para 5.4.3 p116) (NICE 2007)
18. Whooley MA, Avins AL, Miranda J et al. Case-finding instruments for depression. Two questions are as good as many. *Journal of General Internal Medicine* 1997; 12: 439-445
19. Cox JL, Holden J. Perinatal mental health: A guide to the Edinburgh Postnatal Depression Scale (EPDS). Gaskell: London, 2003
20. Glavin K. Preventing and treating postpartum depression in women - a municipality model. *Journal of Research in Nursing* 2012; 17(2): 142-156
21. Brugha TS, Morrell CJ, Slade P, Walters SJ. Universal prevention of depression in women postnatally: cluster randomized trial evidence in primary care. *Psychological Medicine* 2011; 41(4): 739-48