PND:

Postnatal—or perinatal? —depression

Obstetric care has made huge advances in the last century with respect to the mortality and morbidity of mothers and infants. More recent changes, such as shorter hospital stays and high caesarean rates, have come under the scrutiny of a broader range of health professionals than just obstetricians and gynaecologists, with increasing overlap between those researching depression and emotional wellbeing and those delivering perinatal care. Psychiatry too has made significant advances in the last century, with improved treatments, the closing of institutions and improved understanding of the biological underpinnings of mental ill-health. However, with respect to mortality we have not been as successful as obstetricians, with maternal suicide now being the equal leading cause (with haemorrhage) of maternal deaths in Australia.[1]

Table 1

Risk factors for perinatal depression [6]

Risk factors
Major risk factors
• Depression and/or anxiety during pregnancy
• A past history of depression
• Stressful life events
• Low social supports
Moderate risk factors
• Neuroticism (perfectionism)
• Marital difficulties
Minor risk factors
• Pregnancy and delivery complications
• Socioeconomic status (low)

Psychiatry has focused increasingly on pregnancy and postpartum illnesses not just because of the suicide risk which, fortunately, is still small—nor the associated risk of childhood abuse and death for children of mentally ill and substance-abusing parents (the subject of a recent Victorian government review)—but rather because of its high prevalence and the increasing evidence of more subtle long-term negative impacts.

So how common are antenatal and postnatal depression?

A recent meta-analysis revealed that a fairly consistent figure of 13 per cent of women suffer from a major depressive disorder postpartum,[2] some 29 per cent suffer from an adjustment disorder, one in 600 suffer postpartum psychosis and those with bipolar or schizoaffective disorder are at significant risk of relapse, even if they remain on medication (which does however reduce the risk).

It is now becoming increasingly apparent that women are also at-risk antenatally, but they and their treating health professionals are less likely to recognise the disorder, attributing symptoms to the pregnancy.[3] Prevalence of depression in pregnancy has been estimated at 7-26 per cent[4] and 12 per cent of postnatal depressions have a prenatal onset.[5]

In 2001 beyondblue, the national Australian depression initiative, funded a large Australia-wide study of postnatal depression. In the course of this study, which concluded in 2005 and is currently being analysed, we began saying that the 'PND' stood not for postnatal depression but rather perinatal depression. This came from our experience screening 40,000 women across Australia for depression antenatally and postnatally and finding similar levels of anxiety and depression at these times. Further analysis is required to determine if different cut-offs for tools measuring depression are required as has been suggested by other researchers. If so, it means that depression is less common antenatally but still affecting a significant number of women: between 6 per cent and 16 per cent through the perinatal period.

What are the symptoms?

Perinatal depression is similar to depression at other times, with lowered mood, tearfulness, sleep and appetite disturbance and loss of energy and interest. However many of these symptoms can be mistaken for 'normal' changes occurring at this time and a more careful history is required to tease this out. Many have these symptoms postpartum, but women with postnatal depression have more of them, more of the time and they don't 'go away'. In addition, anxiety is

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Table 2

Suggested treatment strategies

Identify

- Routine Screening with a screening tool gives an estimate of risk but a history of symptoms is still required
- Ask every woman about key risk factors
- Ask all women about how they are feeling emotionally
- Provide women with information eg, in antenatal classes, *Emotional Health in Pregnancy* (booklet available in 19 languages at **www.beyondblue.org.au**)

General management issues

- Talk to the partner and family—support and understanding is important
- What other supports are available eg, childcare, mothers groups, depression support groups (eg, PaNDA), health nurse visits
- Group therapy—some capital cities have private mother-baby units which offer day or group programs
- Individual counselling
- Anxiety management eg, CBT, yoga, tapes

Moderate to severe

- Consider antidepressants—a GP or psychiatrist may be the best person to manage this, the latter particularly if the woman is pregnant or lactating. If pregnant, liaising with the psychiatrist and a paediatrician re: induction and management of medication is important.
- Consider admission—preferably to a specialised unit

more common—often infant-related—and suicide less common, except for the more severe postpartum psychosis.

Who is at risk?

Research looking at prediction and risk factors for postnatal depression is extensive and largely consistent. Primarily the risk factors are psychosocial with little evidence of a hormonal basis (see Table 1). Of note, age and education were not found to be associated: important given the ageing of our first-time mothers.

Why is it a problem?

Research over the last 20 years has provided increasing evidence that maternal depression affects not just the mother but the whole family.

The transition to parenthood is difficult for many couples. For those without supports, with high levels of stressful life events and a vulnerability to depression, this may be particularly difficult. The male partner also has a higher rate of depression, with the associated impact on the viability of the relationship and economic impact of being unable to work.

Maternal depression has been seen to adversely affect the child for whom the mother is usually the main carer; this includes the infant mirroring the mother's depression from an early age if they are a girl, becoming disruptive if they are a boy and taking on negative messages about self efficacy which affect behaviour and learning.[7, 8]

More recent works suggests that the negative impact of depression begins, for at least some women, antenatally with effects on blood flow and cortisol levels[9] further adding to the case to name the condition perinatal rather than postnatal depression.

How do women get into treatment?

For many women with perinatal depression, it is the first time they have experienced significant emotional problems. Stigma, desperation to hang onto the myths of motherhood and not be seen as a failure, reluctance to accept the medical model of depression and lack of knowledge on the part of both the woman and health professionals all contribute to many not receiving timely treatment or treatment at all. A number of studies show that if not routinely asked, over half of perinatal depression is missed. If women do go for help, it is often for their infant and not themselves, accounting for much of the increase in facilities for unsettled babies, or 'sleep schools'.

Treatments have been seen to be effective[10, 11] and suggestions for obstetricians and obstetric support staff are given in Table 2.

Conclusions

Postnatal depression is better considered perinatal depression given the significant number of women who are depressed or anxious antenatally, that this is one of the strongest risk factor for later depression and that women can be readily identified at this time. Health professionals seeing perinatal women need to routinely consider emotional healthcare and needs in management if outcomes are to be improved, but to do this obstetric and community services must be able to support them. Our trial involving 34 such services showed that this can be done—if we all work together.

References

1 King JF, Slaytor EK and Sullivan EA. Maternal deaths in Australia 1997-1999. *MJA* 2004;181(8): 413-414.

2 O'Hara MW and Swain AM. Rates and risk of postpartum depression - A meta-analysis. *In Rev Psych* 1996;8:37-54.

3 Buist A, Bilszta J, Barnett B, Milgrom J, Condon J, Hayes B and Brooks J. Recognition and Management of Postnatal Depression in General Practice: Results of a National Survey. *Aust Fam Phys* 2004; In Submission.

4 Moses-Kolko EL and Roth EK. Antepartum and postpartum depression: healthy mom, healthy baby. *J Amer Med Wom Assoc* 2004;59(3):181-191.

5 Stowe ZN, Hostetter AL and Newport DJ. The onset of postpartum depression: Implications for clinical screening in obstetrical and primary care. *Amer J Obstet & Gyn* 2005;192:522-526.

6 Robertson E, Grace S, Wallington T and Stewart DE. Antenatal risk factors for postpartum depression: a synthesis of recent literature. *Gen Hosp Psychiatry* 2004;26:289-295.

7 Murray L and Cooper PJ. Effects of postnatal depression on infant development. *Arch Dis Child* 1997;77(2):99-101.

8 Murray L and Cooper P. Postpartum depression and child development. *Psychol Med* 1997;27: 253-260.

9 O'connor TG, Ben-Shlomo Y, Heron J, Golding J, Adams D and Glover V. Prenatal anxiety predicts individual differences in Cortisol in pre-adolescent children. *Biol Psychiatry* 2005;58: 211-217.

10 Dennis C-LE. Treatment of Postpartum Depression, Part 2: A Critical Review of Nonbiological Interventions. *J Clin Psych* 2004; 65(9):1252-1265.

11 Dennis C-LE and Stewart DE. Treatment of Postpartum Depression, Part 1: A Critical Review of Biological Interventions. *J Clin Psych* 2004; 65(9):1242-1251.