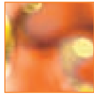

Treatment of perinatal depression

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Summary

If possible, women at risk of depression should be identified during pregnancy. They often do not spontaneously seek help. Early intervention is important for the health of the woman and her baby. Psychological interventions such as support groups are often helpful. Involving the woman's partner can also assist. Antidepressants are required in some cases and women with psychotic symptoms need urgent psychiatric assessment and treatment.

Key words: antidepressants, infants.

(Aust Prescr 2008;31:36–9)

Introduction

Postnatal depression is better termed perinatal depression as it often begins antenatally, although it may not be recognised until the postnatal period. It is a common disorder, with milder adjustment problems and anxiety affecting some 30% of women while about 15% of women have more significant mood disorders, often with anxiety. Women are reluctant to seek help, but early identification and intervention are essential to minimise the long-term complications. These include suicide, chronic depression and marital difficulties, and for the child, cognitive, emotional and behavioural problems.

Identification

Unless women have previously had depression, they rarely recognise it in themselves during the perinatal period. For most, this is their first episode of depression and is unexpected at a time that is anticipated positively. In the antenatal period it is all put down to 'the pregnancy' with the presumption that everything will resolve itself after the baby is born. Historically, pregnancy was thought to be protective against mental illness and suicide, however this is not the case. Mental illness is just less likely to be recognised in pregnancy. Postnatally, there are many reasons why women do not seek help, or at least not for themselves. These include the presence of predominant anxiety rather than depression, a mistaken belief that postnatal depression is somehow linked to not wanting the baby or being a bad mother, the stigma of being seen as a bad mother and the stigma of depression.

Women seek help for the baby, not for themselves. The long waiting lists in mother and baby units and settling facilities are testimony to the very real problem perceived by mothers of their babies having sleeping and feeding difficulties. In some cases this is the primary problem, but often it is the mother's reaction, her high unrealistic expectations and her own depression and anxiety that are the underlying issue.

A key factor in identifying depression is having a suspicion for the condition particularly in women with risk factors (Box 1). Ideally, this risk should be detected during pregnancy. Women with previous perinatal depression or psychosis are particularly at risk of having another episode with future pregnancies. Screening for depression with tools such as the Edinburgh Postnatal Depression Scale can be helpful.[1] Many antenatal clinics and maternal child health nurses do screening and suggest women with high scores (> 12) see a doctor. Adjustment disorders have similar symptoms to depression but fewer, less severe symptoms and with some 'good times' and an ability to see into the future. These disorders usually resolve within three months.

Women with depression have symptoms which last longer than two weeks. They usually have significant anxiety (often related to the baby and their ability to mother), tearfulness, and feel easily overwhelmed and unable to cope with even basic household chores. Biological symptoms (insomnia, appetite changes) not accounted for by disturbed sleep and breastfeeding also suggest a more serious disorder. The severity of symptoms and their impact on the woman's life are the best guides to the need for intervention.

Box 1

Risk factors for perinatal depression

High correlation with increased risk

- Depression in pregnancy
- Past history of affective disorder
- Family history of affective disorder
- Lack of support – partner, mother
- Multiple stressors

Some correlation with increased risk

- Perfectionistic personality
- Low socioeconomic status
- Aboriginal and Torres Strait Islander people
- Childhood abuse

Depression should be distinguished from the less common postpartum psychosis. The latter usually presents in the first few weeks after birth, with confusion, dramatic mood or psychotic symptoms, and requires urgent assessment and inpatient treatment. In all cases if there is a threat to the safety of either the mother or the infant, referral to specialist care or involving protective services may be required. For many women with depression the baby is protective against suicide, but this is not true for women with postpartum psychosis, and suicide remains a leading cause of death.

Engaging

Women are often reluctant to admit how they are feeling and, in some cases, particularly to doctors, who they fear will give them an antidepressant. Women who present frequently to their child health nurse or general practitioner, and do not appear to be their usual selves should be asked again and again about their own health. Talking about normal 'stress' rather than depression, and engineering a view that to get help in fact makes them a good mother, might help break down the barriers over time.

Management

Many women with postnatal depression can be managed, at least initially, without medication. Unless the woman has very significant or long-standing symptoms, it is worth starting with psychosocial management. Antidepressants can be mentioned as one possibility if things do not improve. Although trials have been limited in postnatal depression, evidence suggests that antidepressants do have a role in treatment.[2]

The key to deciding about medication lies largely in diagnosis – is this an adjustment disorder or a major depression? Management must also take into account the woman's particular circumstances (see Box 2). The decision to prescribe is made in conjunction with the woman, and ideally her partner. Some partners are not supportive and may have strong views about the effect of drugs when the woman is pregnant or breastfeeding.

Psychosocial interventions

While postpartum psychosis (a probable variant of bipolar disorders) may have a clear biological aetiology, perinatal depression appears to begin at least as a stress response, in someone predisposed through personality or genetics. While the end result may be biological changes that will respond to medication, unless the stress is dealt with, recovery is likely to be delayed or prevented. In many cases, stress reduces as the baby ages, becomes more predictable, and life develops a routine. Women can be helped as they adapt to their new lifestyle. They need an opportunity to talk about their feelings and experiences. Although there are common themes, they will vary among women. For some a traumatic birth may be an issue, for others not being 'in control' or loss of lifestyle may be crucial to their feelings.

Box 2

When to consider use of antidepressants for perinatal depression

Severe or significant number of symptoms, particularly biological symptoms (e.g. sleep and appetite disturbance)

Persistent symptoms

Response to psychosocial management nil or inadequate

Unable to offer psychosocial management because of cost, distance, or other practical factors

Family or past history of good response to medication

Woman's preference

Therapeutic groups can be effective[3], but new mother groups can be counterproductive with depressed women feeling they are failures compared to the 'normal' mothers around them. A specific group can target the common anxieties of these depressed mothers, such as needing to be perfect and always there for their child, as well as focusing on the relationship with their infant. Many groups also include the partner for at least some sessions as the advent of parenthood and coping with a depressed woman can have a significant effect on the partner's mental health, as well as on the relationship.

It is important to look at the available supports and try to enhance these. Childcare to give the woman a break to have time for herself is often something women desperately need, but feel guilty about. If her main support is her mother or partner and there is conflict in the relationship, it is important to deal with this. Extra stress does not constitute support even if the intention is there.

Specific cognitive behavioural or interpersonal strategies in an individual setting can be helpful, although more research is needed.[4] Referral to a psychologist is worth considering. Relaxation, yoga and meditation can all have benefits, but are difficult for many women to implement. Website-based interventions can be useful such as those provided by the Centre for Clinical Interventions (www.cci.health.wa.gov.au).

Antidepressants in pregnancy

There are risks with antidepressants in pregnancy[5,6], but it is important to balance these largely unknown and seeming relatively low risks with the risks of **not** treating depression. Anxiety and depression in pregnancy can affect the fetus, for example a higher cortisol concentration at birth can be maintained for 10 years.[7] Depressed women are also more likely to smoke, and have poor nutrition and a risk of suicide.

Antidepressants in lactation

The harmful effect of taking antidepressants during lactation needs to be balanced against the benefits for each woman.[6,8] For some women being given permission to cease breastfeeding can be a relief, particularly when anxiety has resulted in decreased milk supply or care of the baby is overwhelming. The risks of antidepressant drugs seem quite low, with the exception of venlafaxine, which appears to be concentrated in the breast milk. Smaller, premature and unwell infants could be more at risk and any subtle effects of drugs in breast milk are unknown.

Mother-infant interaction

There is now extensive literature on the association of maternal depression with an increased risk of poorer mental health outcomes in children.[9,10] While this is clear, the association is not straightforward, and includes a biological influence through genes and stress hormones in pregnancy, as well as the mother's own parenting, her attachment to the child, and her social circumstances.

Research suggests that treating the depression alone does not in itself bring about change in the mother-infant relationship. Depressed and anxious women more often than not want to be good mothers, but their illness, and their own attachment experience may interfere with this, making them less responsive, or over-intrusive or inconsistent. Early intervention is important because in the first year of life, infants form an attachment which is the building block for all later relationships.[11]

General practitioners can think of and watch the relationship between mother and baby. If there are concerns, ask the mother about her feelings and her own experience of being mothered. Suggest ways of making things easier for her that will be better for baby. The 'circle of security', which shows diagrammatically the needs of the child, can be downloaded (www.circleofsecurity.org) and used with women. It is a simple way of showing what young babies need, and a useful talking point. Consider if there is anyone else that could be involved in the child's care. If the mother is very withdrawn, then engage her partner or mother and point out the importance of them providing stimulation to the infant. While this may not seem much, it is important to remember that infants have their own resilience factors. Anything that can enhance these can potentially bring about a better outcome.

When to refer

While most women with perinatal depression can be managed in general practice, referrals can be considered in a number of key situations. Firstly, if there are risks of harm, referral should be made urgently to a parent-infant unit, psychiatric hospital or crisis team depending on local availability and protocol.

An opinion from a psychiatrist specialising in the area can be particularly useful when medication is being contemplated in pregnancy and lactation.

A psychiatry referral for a management plan (Medicare item 291) can be considered when women have not responded to psychosocial management and at least one antidepressant, or when they have not improved and are reluctant to use antidepressants. Referral to a psychologist is also useful in this scenario, and when anxiety is a key feature.

Referral for assessment, or for ongoing care, should be considered for women with comorbid disorders, significant impairment in the mother-infant interaction and where the mother's childhood issues and personality factors are contributing significantly to presentation and poor progress.

Conclusion

Perinatal mood and anxiety disorders are common and have potential long-term negative outcomes for the woman and her infant. Although there is a limited evidence base, medication, cognitive behavioural and interpersonal strategies and support may be of use. Early identification through careful assessment of the patient, her infant and risk factors, awareness of the difficulties women have in recognising and accepting a diagnosis of depression, and specific issues related to the baby, all need consideration in managing women in the perinatal period.

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Conflict of interest: none declared

Self-test questions

The following statements are either true or false *(answers on page 55)*

3. Maternal depression has no effect on the future mental health of the child.
4. Perinatal depression is often underrecognised.

Patient support organisations

Perinatal depression

beyondblue

beyondblue is an Australian independent not-for-profit organisation working to address issues associated with depression, anxiety and related substance misuse disorders. The beyondblue website has informative sections on depression, postnatal depression, anxiety and bipolar disorder. It has recommended links to additional information and contacts in every state and territory.

Website: www.beyondblue.org.au

Telephone information line: 1300 22 4636

Post and Ante Natal Depression Association (PANDA)

PANDA is a Victorian not-for-profit self-help organisation that provides confidential information, support and referral to those affected by post- and antenatal mood disorders, including partners and extended family members. PANDA produces and distributes accurate information about post- and antenatal mood disorders to health professionals and the wider community, in the form of:

- resources and information on antenatal and postnatal depression and postpartum psychosis, on the website and in paper copy
- telephone support and information
- information and referral details for supports and services in your area
- newsletters for members.

Website: www.panda.org.au

Telephone: 1300 726 306 Victoria, (03) 9481 3377 outside Victoria

Book review

Therapeutic Guidelines: Analgesic. Version 5.

Melbourne: Therapeutic Guidelines Limited; 2007. 285 pages. Price $39, students $30, plus postage

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Version 5 updates the previous version of this therapeutic guideline, published in 2002. Its stated aim is 'to provide clear, practical, authoritative and succinct therapeutic information for busy health practitioners'. Although it is not explicitly stated, the target audience appears to be students, junior doctors (including specialist trainees) and general practitioners. In the subject area of analgesia, successive versions have seen an increase in detail about the theoretical and pathophysiological considerations which underpin clinical practice, reflecting the considerable growth in knowledge since the first version appeared in 1988.

The book discusses the mechanisms and pathophysiology of pain, followed by both general and specific information about pharmacology. Non-pharmacological methods are also covered in some detail. Guidelines are provided for assessing pain (including pain in children), managing chronic pain and for a range of specific clinical situations. Despite its compact size, the book is very comprehensive and covers a wide range of situations where pain will need to be assessed and managed. Although much will be very familiar to experienced practitioners, there is still value in reviewing basic knowledge, especially when that knowledge has been added to in the recent past. This book would be invaluable for students and junior doctors, and is likely to be helpful for rural practitioners, given the very wide range of clinical scenarios that they will encounter. It will also be helpful for those who find that the management of chronic pain is becoming more prominent in their day-to-day practice. In short, a useful update of a trusted tool.