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PRACTICE

EASILY MISSED?

Postnatal depression

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This is one of a series of occasional articles highlighting conditions that may be more common than many doctors realise or may be missed at first presentation. The series advisers are Anthony Harnden, university lecturer in general practice, Department of Primary Health Care, University of Oxford, and Richard Lehman, general practitioner, Banbury. To suggest a topic, please email us at practice@bmj.com

A 26 year old woman visited her general practitioner six weeks after the birth of her first baby for her postnatal examination. Initially she mentioned only some problems with breast feeding, but it soon became clear that she was low in mood, and she said she had a difficulty socialising. She minimised her symptoms, however, claiming that she just had a touch of the "baby blues," and she was reluctant to talk about how she was feeling. On closer questioning, she admitted that she felt overwhelmed, anxious about the baby, and guilty about not being a good mother.

What is postnatal depression?

Many women experience the baby blues—mood symptoms that develop within two to three days of birth, peak on the fifth day, and resolve within two weeks. However, episodes of more substantial postnatal depression are also common and can cause considerable disruption for the woman and her family. The most severe form of postpartum mood disorder—postpartum (or puerperal) psychosis—involves the acute onset of a manic, mixed, or depressive psychosis in the immediate postpartum period.

Why is postnatal depression missed?

Good evidence exists that episodes of postpartum depression are missed or misdiagnosed. One study found that only 15% of 211 postpartum women—who according to interview had experienced a mood disorder during the first year after childbirth—had sought help, been prescribed drugs, or had hospital contact.[5] It is also clear that bipolar episodes presenting in the postpartum period might be misdiagnosed as unipolar depression. It is therefore important to consider bipolar disorder in the differential diagnosis of postpartum depressive episodes and to take a careful psychiatric history to rule this out.[6]

The postpartum period is a time when joy is the expectation. Many women are reluctant to admit to mood symptoms because they are embarrassed or stigmatised, and they worry about their child being taken into care.[7] Professionals might collude with women and fail to recognise severe episodes of illness that would benefit from treatment.

Why does this matter?

It is important to distinguish postnatal episodes of major depression from a minor mood disturbance ("baby blues") because treatment for depression can alleviate the considerable distress associated with this condition. Depression of duration longer than two weeks, severe symptoms, or substantial impairment should raise suspicion of an episode of major depression.

Untreated postpartum depression causes substantial impairment to the woman, but might also have detrimental effects on the baby—in terms of emotional, behavioural, and cognitive problems—and might lead to a mood disorder in her partner. Over the past decade, the confidential enquiries into maternal death in the United Kingdom have shown suicide to be a leading cause of maternal death.[8] Problems highlighted by the inquiries include the severity and speed of onset of postpartum illness not being recognised and the misattribution of important non-psychiatric medical conditions to psychological symptoms.

How is postnatal depression diagnosed?

Throughout pregnancy and the puerperium women come into contact with a variety of healthcare professionals including midwives, obstetricians, health visitors, and GPs. It is vital that a woman's mental health is given the same attention as her physical wellbeing. The period of highest risk is in the weeks after delivery, but it is important that the primary care team remains vigilant throughout the year after childbirth. Postnatal depression can be diagnosed only by clinical assessment, but there are strategies that can help with case finding. Although controversial, National Institute for Health and Care Excellence guidelines on antenatal and postnatal mental health recommend

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Box 1 How common is postnatal depression?

- Postpartum blues, or baby blues, is a transient condition that affects 30-80% of women after birth
- The overall prevalence of clinically significant postpartum depressive symptoms is estimated to be between 7% and 19%.[1] Around a third of "postnatal depression" begins in pregnancy and around a quarter begins before pregnancy[2]
- Postpartum psychosis occurs after about 0.1% (1 in 1000) deliveries[3]
- Women with bipolar disorder are at particularly high risk of postnatal depression in the postpartum period, with around half of deliveries followed by a clinically significant postpartum episode[4]

that all women in pregnancy and the postpartum period should be assessed for severe mood symptoms at every contact with all healthcare professionals using a brief, three item screen (Whooley questions, box 2).[9] The questions have a positive predictive value of 32% and a negative predictive value of 99% for major depression but there is a lack of data of their use in the perinatal context.[10]

Another commonly used tool is the Edinburgh postnatal depression scale, a self report, 10 item questionnaire with a sensitivity range from 34% to 100%, and specificity from 44% to 100% in different studies. The most commonly used cut-off score of >12 has an overall positive predictive value of 57% and negative predictive value of 99%.[1]

The aim of screening tools for postnatal depression is not to diagnose depressive disorders but to identify those women who need further clinical and psychiatric assessment. The *International Classification of Diseases 10th revision* (ICD-10) criteria for an episode of major depression are given in box 3. It is vital that all episodes after childbirth are not automatically labelled as postpartum depression but that other conditions such as generalised anxiety disorder, substance misuse disorders, obsessive compulsive disorder, and post-traumatic stress disorder are also considered. In particular, the acute onset of severe mood symptoms or rapid deterioration must be taken seriously and a diagnosis of postpartum psychosis considered. In the assessment it is also important to consider any factors that might have increased the risk of depression, such as domestic violence, and which might need to be dealt with.

The diagnosis of postnatal depression is a syndromal one, but a physical examination and investigations might be important if the history suggests a physical health condition that might present with psychological symptoms. For instance excessive tiredness or weight gain might suggest hypothyroidism and require thyroid function testing.

How is postnatal depression managed?

Depression after childbirth responds to the same treatments as episodes occurring at other times. Treatments range from general support and listening visits by health visitors for mild symptoms, to talking treatments such as cognitive behavioural therapy or interpersonal therapy and antidepressants for moderate to severe episodes.[9-11] Although ICD-10 defines mild, moderate, and severe episodes of depression by symptom count (see box 3), in clinical practice severity is better judged by the impairment the episode is causing and by specific symptoms such as psychotic phenomena.

Postpartum women may be more reluctant to take antidepressants, especially if they are breast feeding (see box 4).

Severe mood episodes, such as postpartum psychosis, are a psychiatric emergency and admission of the woman is almost always required, ideally together with her baby to a mother and baby unit.[12] Although mood stabilising and antipsychotic drugs are key to the treatment of postpartum psychosis in the acute phase, psychological support is likely to be required in the recovery phase. In addition, putting women in touch with support groups such as Action on Postpartum Psychosis (http://www.app-network.org/) can be of great benefit.

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Box 2 Whooley questions

1 During the past month, have you often been bothered by feeling down, depressed, or hopeless?

2 During the past month, have you often been bothered by having little interest or pleasure in doing things?

Consider a third question:

3 Is this something you feel you need or want help with?

Box 3 ICD-10 diagnostic criteria for depression

At least four, six, or eight symptoms are required for at least two weeks to make a diagnosis of mild, moderate, or severe depression, respectively. For mild and moderate depression, at least two group A symptoms must be present and for severe depression all three group A symptoms are required.

Group A symptoms

- Depressed mood to a degree that is abnormal for the person, present for most of the day, largely uninfluenced by circumstances
- Loss of interest or pleasure in activities that are normally pleasurable
- Decreased energy or increased fatiguability

Group B symptoms

- Loss of confidence or self esteem
- Unreasonable feelings of self reproach or excessive and inappropriate guilt
- Recurrent thoughts of death or suicide, or any suicidal behaviour
- Reduced ability to think or concentrate, such as indecisiveness
- Change in psychomotor activity, with agitation or retardation
- Sleep disturbance of any type
- Change in appetite (decrease or increase), with corresponding weight change

Box 4 Use of antidepressants in the postpartum period

Decisions about breast feeding and using antidepressants must be the result of an individualised risk-benefit analysis. Adverse but non-specific events have been reported in infants exposed to antidepressants through breast milk. These events are reported more often after exposure to fluoxetine—for example, irritability or poor feeding, or both—and citalopram—for example, poor sleep—than after exposure to other drugs.[13] No studies have identified an increased risk of adverse longer term outcomes.

Issues to consider include:

- Benefits of breast feeding
- Potential benefit of antidepressant drugs and the impact of relapse and recurrence if the drugs are stopped
- 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 post partum 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

Key points

- Mood disorders are common in the postpartum period but can be missed or misdiagnosed
- Women might be reluctant to discuss mood symptoms because of stigma. Or they might worry about their baby being taken into care
- Screening tools can be helpful to identify postnatal depression but are not substitutes for clinical assessment