

POSTNATAL DEPRESSION

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Introduction

Depression in the puerperium could be classified into 3 forms: postnatal blues, postnatal depression and puerperal psychosis (psychotic depression). Postnatal blues, which occurs in 50%^(1,2) of women after childbirth, refers to a transient period whereby there is lability of mood, episodes of crying and depression. The symptoms reach a peak about 4-5 days after birth and rapidly disappear before the tenth day. Thus, no active treatment is required. Postnatal depression (PND) develops later than the blues, usually in or after the third week and definite symptoms of depression such as anhedonia, insomnia, loss of appetite, loss of weight, ideas of guilt and suicide are present. It could last for weeks, months or even longer than a year. Most recent studies have shown that 10-15%^(2,3) of women suffer from PND. Puerperal psychosis is rare, occurring in 1-2 per 1,000 deliveries. This is a severe form of depression whereby there are hallucinations and delusions. Although PND is 100 times more prevalent than puerperal psychosis, most are undetected. Even when detected, many are inadequately treated and few are referred to the psychiatrist.

Problems of diagnosis

There are reasons why PND is not recognised and is under-reported.

- (i) Obstetricians, general practitioners and midwives have difficulty deciding when the mother's low mood constitutes a depressive illness. Some may hold the attitude that depression is "what most women go through" and that it is "understandable". Some may even be reluctant to make a psychiatric diagnosis.
- (ii) Mothers may be reluctant to describe their emotional feelings for fear of being criticised or of being stigmatised as mentally ill. They may also feel shameful for feeling depressed and of harbouring ideas of self harm and harm to the baby.
- (iii) In certain cultures eg the Chinese culture, expressing depression may not be acceptable. Many who are depressed tend to somatise their emotional problems instead.

In a recent local study, "Postnatal depression in Singapore women" published in this issue, 200 postnatal women were followed-up over a period of 6 months⁽⁴⁾. Using the Edinburgh Postnatal Depression Scale mild depressive symptoms were found to be present in nearly all the postpartum women. However, only one percent were diagnosed to be suffering from PND and none experienced hallucinations or delusions. What could possibly account for the above findings?

Firstly, the incidence rate of PND may not be a true figure as the instrument used viz the Edinburgh Postnatal Depressive

Scale⁽⁵⁾ has not been standardised on our local population. The above study should be replicated after standardising the scale or by using a clinical interview schedule, in order to ascertain if the low incidence of one percent is indeed a true figure. Secondly, as noted earlier, sociocultural factors may produce an underreporting of both the incidence and severity of the locally depressed. If indeed the incidence of one percent is valid, then it is a most significant finding. We may then want to investigate if certain hormonal, psychological or sociocultural factors protect our local women from PND.

Childbearing rituals

It has been suggested that certain rituals and taboos related to childbirth may be protective against depression⁽⁶⁾. For example, the postpartum Chinese custom of "doing the month" consists of several defined rules of behaviour which include being confined to the house during the entire month, prohibition from bathing and consuming "cold" food, not being exposed to the wind and abstaining from sexual intercourse. These rules which are still prevalent allow the Chinese mother to receive extra care and assistance from her relatives. Besides allowing for an enforced rest, this customary ritual gives the mother a specific behavioural norm to follow. Perhaps, elaborate rituals and good social support provide a buffering effect to stressful events.

Adverse consequences of PND

Untreated PND could lead to adverse consequences affecting the patient, the family, the child and society. It may lead to marital discord and disruption of the bonding process between the mother and the newborn. The child's intellectual and emotional development may also be affected⁽⁷⁾. The mother's ability to return to the workforce may be affected resulting in obvious economic consequences both for the family and the employer. Untreated PND may develop into a depressive psychosis resulting in an increased risk of suicide and infanticide. Hence, the importance of preventing, recognising and treating PND adequately.

Prevention

Women who are at risk could be identified antenatally. If given support and counselling the risk of PND in first time mothers could be reduced⁽⁸⁾. Women known to be at risk are:

- (i) those who experience excessive antenatal anxiety especially towards the last trimester,
- (ii) those with a family history of psychiatric disorder,
- (iii) those who have a previous episode of PND or psychosis,
- (iv) those with poor marital relationships and lacking in close and confiding relationships, and
- (v) those with adverse social and economic stress.

As obstetricians and midwives are in regular contact with women during pregnancy, there is a responsibility to detect this high risk group and to arrange appropriate prophylaxis. One key area for future research is the development of a suitable tool for accurate routine identification of those at risk on the basis of antenatal factors.

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Postnatal identification of patients with PND is also important as antenatal risk factors will never be fully predictive. Careful observation in postnatal wards may reveal minute signs and symptoms preceding a full clinical depression. Mothers with severe postnatal blues and those with ambivalent and negative feelings toward their infant are likely to develop PND. Screening for PND should be carried out at postnatal clinics. The diagnosis of PND should be considered if the patient has constant somatic complaints such as fatigue and insomnia, ideas of inability to cope and excessive preoccupation about a healthy baby.

Management of PND

In mild cases of PND, supportive counselling by experienced health professionals⁽⁹⁾ or support from significant others and self-help groups⁽⁸⁾ can be effective. More severe cases will require antidepressant therapy and assessment and treatment by a psychiatrist. Commonly used antidepressants eg amitriptyline and imipramine can be safely prescribed to nursing mothers in recommended doses. If the depression remains intractable, admission to a psychiatric unit and administration of ECT may be necessary.

Conclusion

Obstetricians are the most appropriate health professionals to recognise and help women with PND. Hence, trainee specialists should be educated on postpartum mental disorders especially

PND. It is also important for general practitioners, medical social workers and midwives to be aware of this disorder. Pregnant women should also be informed of PND during antenatal classes as this could raise their awareness of the likely mental problems that could be encountered.

As depression is often amenable to treatment, accurate diagnosis and timely intervention can go a long way towards obviating needless suffering.

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