Singapore Med J 2013; 54(9): 477-481
doi:10.11622/smedj.2013167

CME ARTICLE

Postnatal depression: a family medicine perspective

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You quickly reviewed your notes for your next patient, Zoe Chan's newborn son, who is coming for the fourth review of his prolonged neonatal jaundice. You noted that during the previous three visits, Zoe raised many concerns and questions about her son's well-being and how she believes that she had possibly contributed or worsened her son's jaundice. You also noted that Zoe broke down in tears during two of the three consultations when she shared how her parents-in-law were imposing many restrictive confinement rules on her. You wonder whether she is suffering from postnatal depression and what would be helpful for her.

WHAT IS POSTNATAL BLUES?

Postnatal blues is a common adjustment phase, with almost one in two first-time mothers experiencing a transient condition characterised by mood liability, tearfulness, irritability, anxiousness about caring for the baby, and even mild depressive symptoms. While postnatal blues usually resolves spontaneously within two weeks with support and encouragement from family and friends, some mothers may develop postnatal depression (PND) if their stress level remains high, or if they have pre-existing risk factors.

WHAT IS PND?

PND, also known as postpartum depression, is defined by the fifth edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-5) as depression with the onset of symptoms within four weeks of delivery. Its symptoms are those of non-pregnancy-related depression, often with distinguishing cognitive symptoms related to the baby and motherhood, such as doubting her ability to care for and nurture her baby, and guilt about her inability to feel love for her baby. Symptoms may go unnoticed in the initial period, and patients may only present for help a few weeks or months later, or sometimes, even one year after delivery.

HOW RELEVANT IS THIS TO MY PRACTICE?

PND is common in Singapore. A prospective study conducted in an obstetric setting at a local tertiary hospital showed that the prevalence of PND, when considering both major and minor depression, was 6.8%.[1] It is very important for new mothers with depression to be identified and treated early for the well-being of the mother, her baby and those around her. Untreated depression can result in lasting adverse outcomes such as unfavourable parenting practices,[2] impaired mother-infant bonding, impaired intellectual and emotional development of the infant,[3] maternal suicide, and even infanticide.[4] Maternal suicide is likely to be the leading cause of maternal deaths in a developed country.[5]

ROLE OF THE FAMILY PHYSICIAN

New mothers have many reasons to visit their family physician (e.g. for postnatal reviews, for their babies' developmental screenings and immunisations, and for treatment of acute illnesses). Therefore, family physicians are presented with many opportunities to actively screen mothers for their stressors, coping strategies and support, and offer help when the mothers have difficulty coping.

A local study showed that there was a significantly higher prevalence of depression among women who brought their infants for three or more nonroutine visits to the infant's doctor than those with fewer visits.[6] A high index of suspicion is recommended, and doctors are encouraged to enquire about the presence of depression and the availability of emotional support among mothers who bring their infants for frequent nonroutine visits. Family physicians can provide at-risk mothers with relevant advice and support, as well as offer medication. There are also many local helplines that are available for mothers in distress (Table I). Mothers with persistent coping issues or serious concerns can also be referred for specialist assessment.

WHO ARE THE MOTHERS AT RISK OF PND?

The risk factors for PND are:

- antenatal anxiety and antenatal depression;
- past history of depression;
- family history of depression;
- poor emotional and instrumental support;
- unplanned pregnancy; and
- negative "confinement" experience.

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Table I. List of local resources available for mothers in distress.

Local resources	Contact number
Restructured hospitals	
KKH	6225 5554
Postnatal Depression Intervention Programme	6394 2205
NUH Women's Emotional Health Service	6772 2037
Helplines	
IMH Mental Health Helpline*	6389 2222 (24-hr)
Family Service Centre	1800 838 0100
Counselling and Care Centre	6536 6366
Fei Yue Counselling Centre	6536 1106
Samaritans of Singapore	1800 221 4444 (24-hr)
Singapore Association for Mental Health	1800 283 7019 (Mon–Fri: 0900–1300 hrs, 1400–1800 hrs)
Care Corner (Mandarin)	1800 353 5800 (Daily 1000–2200 hrs)
Association of Women for Action and Research	1800 774 5935 (Mon–Fri: 1500–2130 hrs)
Parent Line (for parents with parenting and childcare issues)	6289 8811 (Mon–Fri: 0900–1700 hrs)

Note: Help from Postpartum Support International is also available at www.postpartum.net. *If facing a mental health crisis, medical help is also available at the 24-hour Emergency Services located in IMH.
IMH: Institute of Mental Health; KKH: KK Women's and Children's Hospital; NUH: National University Hospital

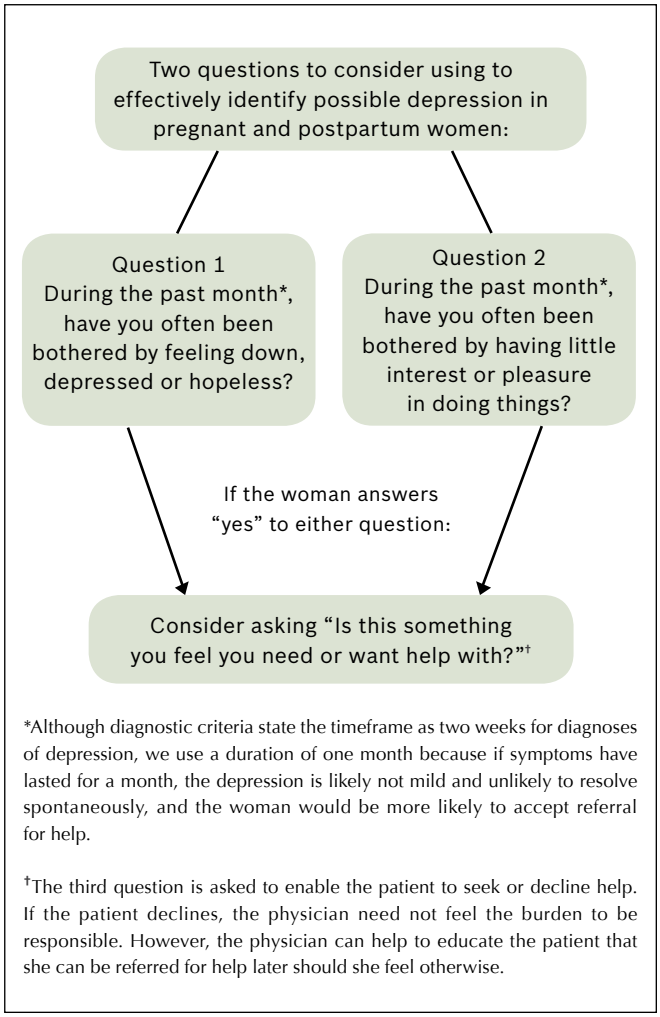

Fig. 1 Diagram shows a schematic for identifying and helping mothers suspected to have postnatal depression [adapted from the Patient Health Questionnaire-2[7,8]].

Common stressors encountered by Singaporean mothers include breastfeeding difficulty, personality factors (especially perfectionistic or anxious types), negative childhood experience, marital discord, family problems (e.g. conflicts with the mother-in-law), childcare difficulties, work-related problems and financial difficulties.

HOW TO SCREEN FOR PND?

If you have a patient whom you suspect is suffering from PND, the adminstration of an easy-to-use, two-question screening tool[7] (Fig. 1) is recommended by the United Kingdom's National Institute for Health and Care Excellence's clinical guidelines.[8]

The Edinburgh Postnatal Depression Scale (EPDS)[9] (see Appendix) is a more robust tool that will require more time to administer. It is a commonly-used screening tool for PND that has been validated locally. A Hong Kong-translated Chinese version that has been validated locally is also available.[10] Mothers who score above a threshold of 12 are likely to be suffering from a depressive illness of varying severity.[10,11]

COMMON BARRIERS AND PITFALLS IN PND MANAGEMENT

The common barriers and pitfalls in PND management can be broadly categorised to patient factors (e.g. a lack of awareness of the condition or the resources available for help, a lack of insight, fear of stigma, fear of having to take medication, the "good mother" trap) and support factors (e.g. a lack of support to seek help, misconceptions about the nature of the condition leading to comments such as "it's all in your mind" and "you should just snap out of this"). Financial difficulty is also a common impediment to help-seeking behaviour.

WHAT TO DO WHEN THE SCREEN IS POSITIVE?

Timely intervention increases the likelihood of good outcomes.[12] Any clinician can offer supportive counselling or a listening ear for the patient to "just talk about it". By giving the mother permission to openly share about her situation, as well as the opportunity to identify her stressors, coping strategies and current support factors, clinicians can normalise the experiences common to Singaporean mothers and clear any myths or misconceptions they may have. Sometimes, mothers need to be reminded that there is no perfect mother and they need not do everything themselves, as seeking help is not wrong. They should be encouraged to explore their own available support systems, such as family and friends. In practice, these women will often appreciate being listened to and having someone concerned about their well-being.

In mild cases, psychosocial intervention may be all that the patient needs.

Women who answer "yes" to either of the two questions in the Patient Health Questionnaire-2, or score high on the EPDS (i.e. EPDS > 12), especially those with a personal history of depression or other major psychiatric disorder, should be offered psychiatric evaluation to confirm the diagnosis and for further treatment. Promethazine can be safely prescribed, even for breastfeeding mothers, for the control of anxiety symptoms and to help with complaints of insomnia. Treatment can be provided by the primary care physician if the depression is mild to moderate, particularly if the mother has no suicidal ideation, care of the mother's infant is not affected and the mother is not nursing. As the issue of the safety of medications during breastfeeding is complex, specialist attention is recommended. Unless the circumstance is extraordinary, it is not advisable to stop women from breastfeeding to take medication. Instead, mothers should be advised to seek specialist attention as the goal should be to facilitate the mothers' breastfeeding wishes. If family members are present, it is also important to educate them about PND and the means by which they can help support the new mother.

You talked to Zoe about her new responsibilities, her home situation, as well as the stress and support she was receiving from people around her. She was noticeably relieved that someone noticed her efforts. She was happy to know that she was not alone with these experiences. She remembered two close friends who had also recently had their first child and decided to contact them for support and to "exchange notes".

Zoe returned with her husband a week later to thank you for your concern. They had agreed to enlist the help of a nanny to help them with the many unfamiliar territories of baby care. This enabled them to catch some sleep in the past three days.

TAKE HOME MESSAGES

1. PND is prevalent and possibly underdiagnosed in primary care settings.
2. Local mothers face many common stressors, which might affect their mental well-being.
3. The primary care physician is in the best position to screen and help mothers with postnatal blues and PND.
4. Screening for and management of postnatal blues and PND can be practical even in a busy clinical practice with the use of short and easy-to-apply screening tools.
5. Singaporean women may not readily request for mental wellness assessments, but they will appreciate being listened to and may be open to talking about their problems with someone who is concerned about their well-being.

ABSTRACT The prevalence of postnatal depression (PND) was reported to be 6.8% in an obstetric setting in Singapore. Since primary care physicians are the healthcare clinicians most likely to interact with postnatal mothers in Singapore, they are in the best position to screen for PND and help new mothers. PND affects the well-being of the mother, her baby and those around her. If left untreated, depression can result in lasting adverse outcomes such as unfavourable parenting practices, impaired mother-infant bonding, impaired intellectual and emotional development of the infant, maternal suicide, and even infanticide. The Edinburgh Postnatal Depression Scale and the Patient Health Questionnaire-2 are effective screening tools that can be easily used in primary care settings for screening at-risk mothers. Herein, we discuss the management options available in primary care settings, as well as share some local resources available to mothers and the benefits of timely intervention.

Keywords: Edinburgh Postnatal Depression Scale, postnatal blues, postnatal depression

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RECOMMENDED READING

Massachusetts General Hospital. MGH Centre for Women's Mental Health. Postpartum Psychiatric Disorders. Available at: www.womensmentalhealth/speciality-clinics/postpartum-psychiatric-disorder.org. Accessed September 10, 2013.

APPENDIX

Edinburgh Postnatal Depression Scale (EPDS)

[Reproduced from Cox JL, Holden JM, Sagovsky R. Detection of postnatal depression. Development of the 10-item Edinburgh Postnatal Depression Scale. Br J Psychiatry 1987; 150:782-6.]

This questionnaire will assist in establishing your emotional state during pregnancy, and at 6-8 weeks after delivery. Please underline the answer which comes closest to how you have felt **in the past 7 days**, not just how you feel today.

1. I have been able to laugh and see the funny side of things.
   (a) As much as I always could
   (b) Not quite so much now
   (c) Definitely not so much now
   (d) Not at all

2. I have looked forward with enjoyment to things.
   (a) As much as I ever did
   (b) Rather less than I used to
   (c) Definitely less than I used to
   (d) Hardly at all

*3. I have blamed myself unnecessarily when things went wrong.
   (a) Yes, most of the time
   (b) Yes, some of the time
   (c) Not very often
   (d) No, never

4. I have been anxious or worried for no good reason.
   (a) No, not at all
   (b) Hardly ever
   (c) Yes, sometimes
   (d) Yes, very often

*5. I have felt scared or panicky for no very good reason.
   (a) Yes, quite a lot
   (b) Yes, sometimes
   (c) No, not much
   (d) No, not at all

*6. Things have been getting on top of me.
   (a) Yes, most of the time I haven't been able to cope at all
   (b) Yes, sometimes I haven't been coping as well as usual
   (c) No, most of the time I have coped quite well
   (d) No, I have been coping as well as ever

*7. I have been so unhappy that I have had difficulty sleeping.
   (a) Yes, most of the time
   (b) Yes, sometimes
   (c) Not very often
   (d) No, not at all

*8. I have felt sad or miserable.
   (a) Yes, most of the time
   (b) Yes, quite often
   (c) Not very often
   (d) No, not at all

*9. I have been so unhappy that I have been crying.
   (a) Yes, most of the time
   (b) Yes, quite often
   (c) Only occasionally
   (d) No, never

*10. The thought of harming myself has occurred to me.
   (a) Yes, quite often
   (b) Sometimes
   (c) Hardly ever
   (d) Never

Response categories are scored 0, 1, 2, and 3 for options (a), (b), (c) and (d), respectively, according to increased severity of the symptoms. Items marked with an asterisk are reverse scored (i.e. 3, 2, 1, and 0 for options (a), (b), (c) and (d), repectively). The total score is calculated by adding together the scores for each of the ten items.

If you score a total of 11 or more, or if you score 1 or more on item 10, it is likely that you are suffering from depression. Please speak to your family physician or his/her clinic nurse, who will advise you appropriately.

SINGAPORE MEDICAL COUNCIL CATEGORY 3B CME PROGRAMME

(Code SMJ 201309A)

	True	False
1. 50% of first-time mothers presenting with mood liability, tearfulness, irritability and anxiousness about caring for the baby in the first postnatal week have postnatal depression (PND).	☐	☐
2. Postnatal blues can spontaneously resolve within two weeks with support and encouragement from family and friends.	☐	☐
3. Mothers with postnatal blues have a higher chance of developing PND if their stress levels remain high, or if they have pre-existing risk factors for depression.	☐	☐
4. PND shares the same diagnostic symptoms as major depression.	☐	☐
5. Symptoms of PND can have the distinguishing feature of cognitive symptoms related to the baby and motherhood.	☐	☐
6. Early identification and treatment of PND will improve the well-being of the mother, her baby and all those around her.	☐	☐
7. Delayed identification or untreated PND can result in lasting adverse outcomes for both the mother and child.	☐	☐
8. Family physicians are not likely to have many opportunities to screen new mothers for their mental well-being.	☐	☐
9. Mothers who bring their infants for three or more nonroutine visits to the infant's doctor are more likely to be better informed on PND and less likely to be depressed than those with fewer visits.	☐	☐
10. Breastfeeding difficulty, premorbid anxious personality, negative childhood experience and negative confinement experiences are common examples of stressors for new Singaporean mothers.	☐	☐
11. The Patient Health Questionnaire-2 and Edinburgh Postnatal Depression Scale (EPDS) are good tools to consider for the screening of PND.	☐	☐
12. The EPDS is only available in English and cannot be adapted for use with Chinese-speaking mothers.	☐	☐
13. Clinicians need specialised training before they can be qualified to offer supportive counselling for mothers with PND or postnatal blues.	☐	☐
14. In PND management, supportive counselling involves allowing mothers to share what they are going through to normalise common experiences and clear any myths or misconceptions.	☐	☐
15. It may be helpful to encourage mothers to explore their own available support systems such as family or friends.	☐	☐
16. Promethazine is inappropriate and not safe for treating breastfeeding mothers with mild anxiety symptoms and insomnia.	☐	☐
17. There are limited community resources, such as helplines, for mothers with postnatal blues or PND.	☐	☐
18. Family physicians do not screen new mothers for their mental wellness as there are limited management options available.	☐	☐
19. Family physicians are presented with many opportunities to screen new mothers for PND, which usually has good outcomes when managed early.	☐	☐
20. Mothers with persistent coping issues or serious depressive symptoms should be referred for specialist assessment.	☐	☐

Doctor's particulars:

Name in full : _____

MCR number : _____ Specialty: _____

Email address : _____

SUBMISSION INSTRUCTIONS:

(1) Log on at the SMJ website: http://www.sma.org.sg/publications/smjcurrentissue.aspx and select the appropriate set of questions. (2) Provide your name, email address and MCR number. (3) Select your answers and click "Submit".

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(1) Answers will be published in the SMJ November 2013 issue. (2) The MCR numbers of successful candidates will be posted online at the SMJ website by 25 October 2013. (3) Passing mark is 60%. No mark will be deducted for incorrect answers. (4) The SMJ editorial office will submit the list of successful candidates to the Singapore Medical Council. (5) One CME point is awarded for successful candidates.

Deadline for submission: (September 2013 SMJ 3B CME programme): 12 noon, 18 October 2013.