Identification and treatment of postnatal depression in primary care

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Abstract

Perinatal mental illness can result in significant morbidity. Most of these illnesses are depressive and anxiety disorders. A systematic review of 28 prospective studies carried out in 11 different countries showed that the prevalence of perinatal depression amongst new mothers during pregnancy and the first few months following childbirth was 12.9%. Thus, the identification of this condition is highly important. The two 'Whooley questions' (*"During the past month, have you often been bothered by feeling down, depressed or hopeless?"* and *"During the past month have you often been bothered by little interest or pleasure in doing things?"*) together with the 'Aroll question' (*"Is this something with which you would like help?"*) can be used to screen for depression. Treatment of postnatal depression can include non-pharmacological and/or pharmacological measures. Breastfeeding intentions should be taken into account when planning treatment for these mothers.

Keywords: postnatal, depression, detection, treatment, breastfeeding

Introduction

Perinatal mental health incorporates the emotional wellbeing of the mother, father and the infant. Several physical, psychological, social and environmental changes occur during pregnancy and the postpartum period which can increase the woman's susceptibility and vulnerability to mental health problems (1-3). The presence of perinatal mental illness, which can range in severity, can result in significant morbidity. Most of these illnesses are depressive and anxiety disorders (4, 5). Postpartum psychosis is much less common, and usually manifests itself as bipolar disorder (6).

Perinatal psychiatric disorders represent a significant pervasive public health problem (7, 8). There may be negative implications across multiple domains - for the mother, the partner (9) and their relationship, the unborn child/infant, as well as any other children within the family unit (10).

What is postnatal depression?

The classification system of the Diagnostic and Statistical Manual (DSM-IV) recognised major depressive disorder with postpartum onset for the first time in 1994 (11). Major depression is defined as having five or more of the following symptoms: depressed mood, loss of interest, change in appetite, sleep disturbance, decrease in energy, feelings of worthlessness, impaired concentration, recurrent thoughts of death, and observed retardation or agitation, lasting for at least two weeks and having their onset within four weeks of delivering a child. In the DSM-5, the diagnosis of depression still utilised the onset specifier format but changed it to 'peripartum onset' (12). This includes a depressive episode which starts in pregnancy or up to four weeks postpartum. For the first time, depression during pregnancy has been recognised.

The International Statistical Classification of Diseases and Related Health Problems, Tenth Revision (ICD-10), does not recognise postnatal depression as a separate diagnosis. In ICD-10 a postnatal onset is considered to be within six weeks after delivery, and classification of conditions in the puerperium (F53) can be made only when they cannot be classified elsewhere. It is considered that in ICD-11 the situation may change (13).

Prevalence

In a systematic review conducted by Gavin et al. (5), 28 prospective studies were carried out in 11 different countries. The prevalence of perinatal depression amongst new mothers during the antenatal months and first few months postpartum was 12.9%. This showed that not all women 'bloom' with good health during pregnancy and that mood disorders can occur also during the months of pregnancy (14).

Antenatal depression is less frequently detected and treated when compared to depression in non-childbearing women, despite both conditions having a similar prevalence (15). A reason for this could be that antenatal depression is often missed, and only identified during the postpartum period. A study by Wisner et al. (2) found that 33% of postpartum depression cases had their onset during pregnancy and 27% before pregnancy. Similarly, Howard et al. (16) found that 50-70% of postpartum depression and anxiety began in pregnancy, and this was often associated with significant comorbidity (6).

Identification of postnatal depression

The National Institute of Health and Care Excellence (NICE) guidelines (8) highlight the importance of early recognition of perinatal mental health disorders and the provision of appropriate and timely access to effective treatment and services. In the clinical setting, screening for perinatal depression focuses mainly on the detection of depressive symptomatology. The Edinburgh Post-Natal Depression Scale (EPDS) (17) has been devised specifically to be used in perinatal women. The EPDS, a 10-item self-report questionnaire which takes approximately 5 - 10 minutes to complete, was found to be acceptable by patients and professionals (18).

When clinicians rely on non-systemic assessment for detection of perinatal depression, there is a high probability that the disorder will be missed, leading to a lower detection rate. This emphasises the importance of having a validated screening tool as part of the clinical assessment (19, 20).

To improve detection of depressive symptomatology, NICE guidelines (8) recommend that healthcare professionals use the two 'Whooley questions' and the additional 'Aroll help question' (21). These verbal questions are delivered in an interview format. The 'Whooley questions' include the following: *"During the past month have you often been bothered by feeling down, depressed or hopeless?"* and *"During the past month have you often been bothered by little interest or pleasure in doing things?"* (22). After these two questions, the 'Aroll question': *"Is this something with which you would like help?"* should follow (23).

The Whooley questions should be asked both antenatally and postnatally at 6-8 weeks and 3-4 months respectively. The brevity of these questions, including the lack of a scoring system, are some of the advantages associated with their use (8). Darwin et al. (24) validated and compared the use of the Whooley questions and the Arroll help question against the EPDS in 191 women registered at an inner-city hospital. The authors stated that the Whooley question only identified half of the cases that were picked up when the EPDS was administered. A lower detection rate was also reported when the Arroll question was used (24).

To be able to identify high-risk cases, screening and case identification should be endorsed. However, there are still various ongoing controversial issues with regard to screening (25, 26). Screening is defined as follows: "A complex process that includes detection, evaluation, engagement, intervention, reduction of symptoms or risk and achievement of functional improvement" (27). Such a definition emphasises the importance of having appropriate pathways in place to institute the correct treatment when screening is introduced. This can be based on a model known as the 'depression treatment cascade' proposed by Pence (28) for use in primary care. It consists of multiple steps which include clinical recognition, initiation of adequate treatment, and remission of depression. Such a model leads to better outcomes. For it to be effective, it requires the collaborative participation of both the patient and the provider.

Clinical effectiveness of perinatal screening for depression

In a systematic review, Myers et al. (18) compared the effectiveness of three randomised controlled trials in reducing maternal depressive symptomatology in perinatal depression (29-31). The three studies implemented an integrated plan whereby healthcare workers were trained to identify women using the

EPDS and to develop clinical assessment skills consisting of non-directive counselling or psychologically-informed sessions to use in their management pathways. One advantage of the studies by Yawn et al. (31) and Leung et al. (30) was that women were managed at the same health service without requiring an outside referral. Paulden (32) assessed the cost-effectiveness of screening for postnatal depression, finding the use of a structured clinical interview to confirm a positive test on the EPDS to be cost-saving as opposed to not including such interview (33).

Treatment of postnatal depression

Perinatal mental disorders are treatable conditions. There has been an exponential rise in clinical trials evaluating psychological and pharmacological interventions in the treatment of perinatal depression. Despite this, there is insufficient evidence to conclude that any of these approaches have a preventative role (34).

Prompt intervention could allow for remission of the mother's depressive symptoms with a subsequent positive impact on the mother-infant relationship and the child's well-being and developmental trajectory.

Non-pharmacological treatment

In mild-to-moderate disorders, non-pharmacological therapy should be the first-line treatment modality. Mothers may prefer psychological interventions, considering the potential risks of drug exposure in-utero or on the breast-fed infant. The most commonly studied psychotherapies include interpersonal therapy (IPT) and cognitive behavioural therapy (CBT).

Given that all treatment options carry a degree of risk, the current recommendation is for each decision to be individualised and tailored specifically to the named case.

Antidepressant medication

Although antidepressants form the mainstay of treatment in moderate-to-severe postnatal depression in which psychological interventions have been ineffective and/or where there are substantial ongoing risks to the mother and/or infant, few randomised trials have been conducted to date. There is conflicting evidence for the effectiveness of antidepressants. Furthermore, there is no evidence showing the superiority of one antidepressant over another in the prevention and treatment of this illness (35).

In view of the limited research base available, healthcare professionals need to draw on other evidence when making such treatment decisions. The severity of the disorder, patient preferences/wishes and previous response to treatment are among the main factors to be considered during the decision-making process.

Antidepressant medication and breastfeeding

If the mother is breastfeeding, the treating doctor must take into consideration both the mother as well as the infant. Even though most psychotropic medications pass from maternal plasma to the breast milk, there has not been any published literature showing high rates of adverse effects on infants. Furthermore, there is a paucity of clinical data on the short-term and long-term effects of antidepressant exposure in infants (35). Despite this, the use of antidepressant medication in breastfeeding women is widely used and is viewed as a logical treatment option (33).

During the decision-making process, any potential risks to an infant from exposure to medications via breast milk should be balanced against the adverse impact of untreated maternal depression on the infant's development. Treatment of maternal illness should take the highest priority and withholding treatment to allow for breastfeeding would be inappropriate in such a situation.

Infant drug exposure is generally higher through placental passage than through the breast milk. Hence, whilst breastfeeding, it is recommended to continue the same psychotropic drug as the one used during the antenatal period, to minimise the number of medications to which the infant is exposed, and to reduce the risk of withdrawal symptoms in the child. Routine clinical monitoring of the breast-fed infant

for any potential adverse effects, including monitoring feeding patterns, growth and development should take place.

When psychotropic medication is prescribed to breastfeeding mothers, it is generally recommended to use a single agent at the lowest possible effective dose and to time dosing to avoid feeding at peak plasma/milk levels. Monitoring of the maternal and infant serum concentrations may also be considered.

Decision making

The patient's support network, partners and significant others, should be included in the decision-making process and in treatment planning. They should be educated about the illness, including signs and symptoms. Information about the potential risks and benefits of each available treatment option should also be given. Such an approach will allow the mother to make an informed decision regarding choice of treatment, for her own health and that of her infant.

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