By Eamonn Brady MPSI

Postnatal depression

Postnatal depression is a form of depression that may be experienced by women after childbirth. For the purpose of the article I will refer to post natal depression as PND for short. It is reckoned that one in seven women[1] suffer from it after giving birth and it usually develops within four to six weeks after childbirth; in some cases it takes several months to develop.[2] Postnatal depression rates are higher in teenage mothers. PND affects all ethnic groups to the same extent.

The symptoms are similar to classic clinical depression, including low mood, anxiety, finding it hard to cope and sleeping problems. Many women put it down to the stress, worry and lack of sleep experienced by most women in the initial period after a baby is born so they may not realize they are experiencing post natal depression.

Many women experience mood changes, irritability and bouts of crying after birth; this is often called “baby blues”. About 30% of mothers are thought to suffer from baby blues and it can last for a few days but usually no longer than 10 days after birth.[3] During this time the mother may be irritable and tearful, but it passes quickly and treatment is not needed.

“Baby blues” generally clears up within a few weeks but post natal depression is more persistent and has a more profound effect on a mother post birth. It can lead to long term depression if not recognized and treated. Postnatal depression is as distressing as other forms of depression.

Causes

The reasons for postnatal depression are not fully understood; there is generally not one single cause. Factors that increase the risk of PND include

- hormonal changes after pregnancy
- the stress of looking after a newborn baby
- individual social circumstances such as an unplanned pregnancy, money or relationship problems
- little support at home
- having no close family or friends near by
- a difficult birth
- physical health problems due to the birth, such as temporary urinary incontinence, pain, scarring from a caesarian, etc

The risk of developing post natal depression is increased in women who have a previous history of postnatal depression; have depression or anxiety during pregnancy or have a previous history of depression or other mood disorders such as anxiety or bipolar disorder.

Even without any of the risk factors mentioned; having a baby can sufficiently stressful and life-changing to trigger depression. Dealing with a newborn is difficult, even for those who already have children. Some babies can be more demanding and difficult to settle making it more difficult and stressful to manage.

Like most psychiatric type disorders, genetics may play a role.[4] A family history of depression or postnatal depression can increase the risk of PND but the extent of this increased risk is not clear.

Symptoms

The symptoms are similar to clinical depression.[5] Primary symptoms include:

- constant feeling of sadness and low mood
- loss of interest in everyday activities that you normally enjoy
- No energy and always feeling tired

Other symptoms can include:

- disturbed sleep
- poor concentration and decision making ability
- low self-esteem
- loss of appetite or an increase in appetite ("comfort eating")
- agitation or alternatively apathy (cannot be bothered)
- feelings of guilt and shame
- thoughts of suicide and self-harm
- thought of harm to the baby (harm to the baby is extremely rare)

Postnatal depression can interfere with day-to-day living and may even interfere with the mother's ability to look after their baby if not treated promptly. Thankfully treatment is successful for the majority of women.

Warning signs to look out for

Many mothers do not realise they have postnatal depression or feel ashamed about it so will not talk about their feelings even with those closest to them. It is often partners, family and friends who recognise signs of postnatal depression. Warning signs include:

- Regularly crying for no obvious reason.
- Not bonding with their baby.
- Neglecting appearance and hygiene (eg) not washing or changing clothes, looking uncharacteristically unkempt
- Losing their usual sense of humour or uncharacteristically taking everything seriously
- Constantly worried that there is problems with the baby (even though consensus including medical checks shows there is not).

Postnatal psychosis

Postnatal psychosis is a rarer and more serious mental health problem that can develop after birth. It affects about 1 in 1,000 women.[6]

Symptoms of postnatal psychosis include:

- bipolar-like symptoms (ie) alternating between high and low mood
- delusions (beliefs that are obviously untrue) usually relating to the baby, such as thinking the baby is sick or dying
- hallucinations (eg) voices telling you to harm the baby

Postnatal psychosis is considered a medical emergency. The GP should be contacted immediately.

Diagnosing postnatal depression

A GP can generally determine that postnatal depression is a possibility by asking if the following is true in the last month:

- have you been feeling down, depressed or hopeless?
- Have you had little interest in doing things that you normally enjoy?

Answering yes to one of these questions can mean postnatal depression is a possibility. If the answer is yes to both these questions, postnatal depression is likely. Many women are reluctant to answer these questions honestly as they may feel it is a negative reflection on them or their mothering skills which is not true.

Other tests

Blood tests such as checks for an underactive thyroid gland or anaemia (low red blood cells which can lead to tiredness) may be done to rule out physical problems that could be causing tiredness and low mood. These problems are common after having a baby.

Edinburgh Postnatal Depression Scale (EPDS) is a questionnaire that can be used to help assess the mother's situation by focusing on certain symptoms and difficulties often associated with postnatal depression.[2] It can also check the response to treatment after treatment has commenced.

Assessing the severity of postnatal depression

Symptoms which will be checked for to determine the severity of PND include:

- disturbed sleep
- problems concentrating or making decisions
- a loss of appetite or increased appetite (comfort eating is often a symptom of depression)
- feeling anxious
- feeling tired, lethargic and unwilling to undertake physical activity
- low self-confidence
- feeling guilt
- suicidal thoughts

The number of symptoms the person has in total, and above all their severity and persistence. This determines whether the depression is mild, moderate or severe.

Three of the above symptoms can indicate mild depression. Five or six symptoms indicate moderate depression. Moderate depression can cause great difficulty carrying out normal activities. Mild and moderate GP can be treated through your GP and his/her primary care team. Having all of the above symptoms generally means severe depression. This can mean inability to function at all. Referral to specialists such as the local community mental health service is advised for severe depression.

Treatment

Once postnatal depression is recognised and treated, recovery can be quick. Treatment for postnatal depression includes:

- self-help and lifestyle changes

- talking therapies such as cognitive behavioural therapy
- antidepressant medication (should never be considered first choice)

One of the main goals of treatment of postnatal depression is to help the mother care for and bond with her baby.

Support and advice

Recognising the problem and realising action needs to be taken is an important first step. To benefit from this, it is important for the new mother to talk to those close to her and explain how they feel. Bottling everything up can cause tension, especially with a partner who may blame themselves if they do not understand what is going on.

Support and advice from social workers or counselors can be helpful. Self-help groups can provide good advice about how to cope with the effects of postnatal depression. It can be reassuring to meet other women suffering from the same problems.

Exercise

Exercise has been proven to help depression, and can provide excellent relief. Exercise releases good mood hormones and relieves stress.

Psychological treatments

Psychological therapies are usually recommended as the first line of treatment for mild-to-moderate postnatal depression for women with no previous history of mental health conditions.

Some common ones are discussed below.

Guided self-help through books
Guided self-help is based on the principle that your GP can "help you to help yourself". Westmeath County Library, Mullingar (and local libraries in other areas) operate a Healthy Reading Scheme were they offer access to books on all areas of mental help including depression, post natal depression, anxiety, self-esteem, stress, etc. For those feeling overwhelmed and isolated, a book can offer a first step in a way that offers no judgement. Contact Westmeath County Library at 04493 32270 (e-mail: library@westmeathcoco.ie) for more information. Self-help books are now being provided more and more as an effective low intensity intervention and proven means of providing psychological therapy for people experiencing mild emotional and psychological difficulties. Suitable books will typically provide people with an insight into their mental health difficulties and teach people the skills to effectively manage their problems.

Guided self-help through computerised CBT
Cognitive Behavioural Therapy (CBT) is based on the theory that peoples' emotions and behaviour are influenced by their perception of events. It is not the situation in itself that determines what people feel but rather the way in which they react and feel about the situation. More detailed information on CBT can be obtained in Whelehans Pharmacy including details of CBT therapists locally. Traditionally CBT is traditionally done one to one with a therapist. Nowadays, a number of interactive software programmes are available that replicate some functions of a CBT therapist. These internet based CBT therapies are called computerised CBT. A computerised CBT self-help programme recommended by NHS in the UK is *Beating the Blues* (for people with mild to moderate depression, www.beatingtheblues.co.uk) which consists of eight 50-minute sessions completed

online. It can also be accessed by people in Ireland for a fee of around €165.38. Some people prefer using a computer rather than talking to a therapist about their personal feelings. The software can also be used as an introduction to CBT, helping develop knowledge and skills that will facilitate more effective one-to-one therapy. Evidence suggests that using computerised CBT packages can help treat anxiety and depressive disorders, particularly when used in conjunction with a therapist.

Guided self-help through internet therapies
Internet therapies can also be undertaken solely by the individual (i.e. self-help). These 'e-therapies' are easily accessible and have been shown to be effective for a range of psychological difficulties including depression, PND, anxiety, eating disorders and insomnia.

It is important to distinguish internet therapies from cCBT. For example, internet-based therapies could refer to, or include, those therapies that are delivered in 'real-time' (i.e., via instant messaging) whereas cCBT is more like a self-help course (that may or may not have intermittent therapist assistance)

Studies indicate that internet therapies can be as effective as face-to-face therapies. Internet therapies are still in their infancy, but there is growing evidence that they can help people through mental health difficulties including mild to moderate anxiety and depression. Unlike the UK, Internet therapies are not yet widely available in Ireland. However, in addition to computerised CBT options I mentioned earlier, there are an increasing number of internet-based therapies available in Ireland. For example, the online mental health promotion project, *HeadsUp* (www.headsup.ie) that is run by the Rehab Group is a website aimed to provide support to 15 to 24 year olds experiencing mental health difficulties. *Headsup* provides online CBT skills programme for free for adolescents and young adults. In addition, many voluntary listening services such as Aware (for depression, www.aware.ie) have recently added online support (e.g., via email and online support groups) to their range of services.

Talking therapies
During talking therapies the mother is encouraged to talk through problems either one-to-one (with a counselor) or with a group. This helps discuss ways to approach problems in a more positive manner.

Two commonly used talking therapies used in the treatment of postnatal depression are:

- cognitive behavioural therapy
- interpersonal therapy

Cognitive behavioural therapy
CBT is a form of therapy that emphasises the important role of thinking in how we feel and what we do. CBT challenges the automatic thoughts and assumptions behind behaviour in postnatal depression. CBT aims to break this cycle and find new ways of thinking that can help you behave in a more positive way. For example, thinking there is a perfect ideal of "motherly behaviour" is both unrealistic and unhelpful. All mothers are human and everyone make mistakes. It is neither necessary nor helpful to attempt to be the "perfect mother". CBT is usually provided in four to six weekly sessions.

Interpersonal therapy
Interpersonal therapy (IPT) aims to determine if relationships with others may be contributing

toward feelings of depression. Like CBT, IPT is usually undertaken in four to six weekly sessions.

Antidepressants

The use of antidepressants may be recommended for:

- Moderate postnatal depression with a previous history of depression.
- Severe postnatal depression.
- Non response to counseling or CBT
- Mothers who prefer to try medication rather than talking therapies first.

A combination of talking therapies and an antidepressant may be required.

Antidepressants work by balancing mood-altering chemicals in the brain. They can help ease symptoms such as low mood, irritability, lack of concentration, difficulty coping and sleeplessness. Antidepressants called Serotonin Selective Reuptake inhibitors (SSRIs) are the most commonly prescribed antidepressants for PND. This is also the case for clinical depression; the reason being is that SSRIs tend to have fewer side effects than older antidepressants such as tricyclic antidepressants.

When a person is initially prescribed an SSRI, they should be clearly informed of the benefits and risks of SSRI. The patient should be informed that antidepressants are not habit forming and craving and tolerance do not occur. There is a risk of withdrawal symptoms on stopping the drug, missing doses, or reducing the dose; therefore SSRIs should only be discontinued in consultation with the patient's GP and should be reduced slowly (eg) the dose reduced over a few days or weeks and then stopped. Potential side-effects of SSRIs include nausea, worsening anxiety, suicidal thoughts, self-harm, restlessness and agitation; these side effects more commonly occur in the first few weeks of treatment. Side effects like nausea and agitation usually subside after a few weeks. SSRIs normally take about 2 to 4 weeks to start relieving depression. For PND, a SSRI will generally be used for between for between 6 to 9 months; in some cases it may be prescribed for longer.

Between 50% and 70% of women who have moderate to severe postnatal depression improve within a few weeks of starting antidepressants. However, antidepressants do not work for everyone.

Antidepressants and breastfeeding

Psychological treatment should be first choice with medication only being considered if this fails. Selective serotonin reuptake inhibitors (SSRI) antidepressants are usually recommended for women who are breastfeeding as studies show that the amount of SSRIs found in breast milk is so small it is unlikely to be harmful to the baby. The benefits often outweigh the risks. As with all drugs taken while breast feeding, the infant should be monitored regularly for sedation; irritability; and changes to sleep, feeding, and growth.
Apart from the well recognised health benefits of breastfeeding, breastfeeding also helps the mother bond with their child and boosts the mother's self-esteem and confidence in maternal abilities. These are important factors in combating symptoms of postnatal depression. Because of lack of data, newer antidepressants, such as mirtazapine and venlafaxine, are not recommended for breastfeeding mothers.

Treating severe postnatal depression

Referral

Referral by a GP to a mental health team (local community mental health service) may be required if postnatal depression is severe, or does not respond to treatment. Community mental health

teams are usually made up of a range of specialists, including psychologists, psychiatrists, specialist nurses and occupational therapists, and can provide intensive talking treatments such as psychotherapy.

Other Medication
As discussed earlier, postnatal psychosis can occur in small number of mothers after birth (about 1 in a 1000). Psychosis is a temporary mental state where the person is unable to tell the difference between reality and their imagination.

Medication that may be prescribed for postnatal psychosis includes:

- mood-stabling medications such as lithium or an anti-epileptic drug
- an antipsychotic (this helps combat the symptoms of psychosis)
- an anti-anxiety drug such as a benzodiazepine (short term only) to help the person relax

Breastfeeding must be stopped while taking these types of medications.

Electroconvulsive therapy (ECT)
Electroconvulsive therapy (ECT) may be recommended for very severe postnatal depression. ECT is only used when antidepressants and other treatments have not worked.

If ECT is recommended, it can be given under general anaesthetic. Electrodes are placed on the head and a pulse of electricity passed through the brain. Most people have either six or twelve sessions of ECT, normally with two sessions a week. For most people, ECT is effective in relieving severe depression, but it is necessary to take antidepressants afterwards to keep symptoms under control. Even though ECT has been used for over 50 years, it is unclear how ECT works, but the generally agreed view is that electricity changes the chemical composition of the brain in such a way as to elevate mood.

Some people experience unpleasant side effects after having ECT, including headaches and both short-term and long-term memory loss. Due to the risk of memory loss, memory will be assessed at the end of each ECT session. If it looks like your memory is being affected, or other adverse side effects occur, ECT will not be continued. Most people tolerate ECT very well. ECT has a bad name from inappropriate use in years gone by, however nowadays it is very strictly controlled and it can be a very successful treatment.

Preventing postnatal depression

To try to prevent postnatal depression, an expecting mother should tell their GP about any previous depression or any severe anxiety that occurs during pregnancy. Also speak to your GP if you have had postnatal depression in the past and are pregnant or considering having another baby, as there can be a risk that postnatal depression will develop again.

Keeping your GP informed will ensure they are aware of the possibility of postnatal depression after your baby is born. This helps prevent delay in diagnosis, and allows treatment to begin earlier. In the early stages, postnatal depression can be easy to miss.

The following self-help measures can help prevent PND:

- Get as much rest and relaxation as possible.
- Take regular gentle exercise.
- Don't go for long periods without food because low blood sugar levels can cause anxiety and mood swings

- Don't drink too much alcohol
- Eat a healthy, balanced diet.
- Talk about your worries with your partner, close family and friends.
- Contact local support groups or national helplines for advice and support.
- Don't try to do everything at once. Avoid extra challenges either during pregnancy or in the first year after your baby is born. A new baby is enough of a challenge for most people.
- You're not alone. Postnatal depression can affect anyone. More than 10% of new mothers suffer from it.

Preventative treatment

If the risk of developing postnatal depression is thought to be especially high, anti-depressants (SSRIs are the most effective) may be recommended as a precaution shortly or soon after giving birth.[7, 8] If a mother has a history of bipolar disorder or psychosis, lithium may be recommended as a precaution shortly before or soon after giving birth. Lithium has a mood-stabilising effect and can often help prevent psychosis reoccurring.

References

1. O'Hara M, Swain A. Rates and risk of postpartum depression: a meta-analysis. International Review of Psychiatry 1996; 8:37-54.
2. Charles Musters, Elizabeth McDonald, Ian Jones. BMJ 2008; 337:a736
3. Harris B, Lovett L, Newcombe R, Read F, Walkler R, Riad-Fahmy D.Maternity blues and major endocrine changes: Cardiff puerperal mood and hormone study II. BMJ 1994; 308:949-53.
4. Forty L, Jones L, Macgregor S, Caesar S, Cooper C, Hough A, et al. Familiarity of postpartum depression in unipolar disorder: results of a family study. American Journal of Psychiatry 2006; 163:1549-53.
5. Cooper C, Jones L, Dunn E, Forty L, Haque S, Oyebode F, et al. Clinical presentation of postnatal and non-postnatal depressive episodes. Psychological Medicine (Cambridge) 2007; 37: 1273-80.
6. Munk-Olsen T, Laursen T, Pedersen C, Mors O, Mortensen P. New parents and mental disorders: a population-based register study. JAMA 2006; 296:2582-9.
7. Wisner K, Perel J, PeindlK, HanusaB, Findling R, Rapport D. Prevention of recurrent postpartum depression: a randomized clinical trial. Journal of Clinical Psychiatry 2001; 62:82-6.
8. Wisner K, Perel J, Peindl K, HanusaB, Piontek C, Findling R. Prevention of postpartum depression: a pilot randomised clinical trial. American Journal of Psychiatry 2004; 161:1290-2.