The assessment and treatment of postnatal depression

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Postnatal depression is a common depressive illness with a variety of potential causes. This article outlines the detection of postnatal depression, the effects that the condition has on the whole family and treatment options.

Postnatal depression affects at least one in ten mothers (Beck, 2001; Cox et al, 1987) and is one of the most common depressive illnesses (Henshaw, 2003). Nurses should be vigilant in looking for the signs and symptoms of postnatal depression in order to ensure that women with the condition are appropriately assessed and treated (Box 1). It can occur at any time during the first year after childbirth but is usually detected four to six weeks after the baby is born.

Identifying the ‘baby blues’
Most nurses, midwives and mothers are familiar with the ‘baby blues’, described by Pitt (1973) as a ‘trivial fleeting phenomenon’. The most common symptoms are tearfulness and oversensitivity, which usually last no more than a few days. However, these feelings may fail to subside and instead can insidiously increase in severity. Sometimes both the mother and her family fail to recognise that this prolonged and inconsistent state of unhappiness is abnormal. The message often portrayed in the media is that childbirth is a joyous experience and mothers have no cause to be miserable. As a result mothers may be reluctant to seek help or decline any interventions offered by family and friends. In some cases mothers may deny their condition and go to extremes to mask their symptoms to avoid being labelled ‘mad’ or a ‘bad’ mother.

Causes of the condition
Several studies (Harlow, 2003; Beeber, 2002) have found that any mother may be affected by postnatal depression and there is no relationship between this and their social class, age, race or educational status. There are many theories about the cause of postnatal depression. It was thought that hormone levels were responsible for mood changes and significant work was undertaken on the impact of hormones. Research was also carried out on the function of the thyroid and whether thyroid-antibody-positive women were more susceptible to postnatal depression. The effect of oestrogen on mood was also studied, with some researchers concentrating on how the system adapted to the deficiency of progesterone. However, most of this work proved inconclusive.

Social support
Social support is vital during the postnatal period and allows the mother time to recover from the baby’s birth and reaffirm her role. If the mother is not relieved of some of her household chores or helped with her baby’s care, there is little chance she will be able to adapt to her new circumstances. She may also become overwhelmed by her infant’s demands. These factors can have damaging effects on her self-esteem and confidence.

Body image and relationships
Some mothers are unprepared for the impact of childbirth despite the information they receive in antenatal class. Their main priority is to deliver a healthy baby. Although they are aware of changes in the antenatal period, they are sometimes disappointed by the physical changes following childbirth and can be distressed at their weight gain and altered body shape. There seems little time to apply make-up, tend to hairstyles or even get dressed in the morning. This can have an impact on the woman’s relationship with her partner who may resent the change in her appearance.

A lack of libido – a common, unspoken complaint – may have devastating consequences for a relationship.

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especially if the partner feels neglected by the mother who appears more preoccupied with her infant’s needs than his.

Care of the infant
Infant feeds are frequent and sleepless nights or waking every three hours also take their toll, not only physically but mentally. Assumptions are often made that the mother only has herself and her infant to consider. However, everyday worries do not disappear. If the mother is already finding it difficult to cope, this situation may magnify her problems out of all proportion and only burden her with even more pressure.

Effects on the family
Over the past 20 years there has been increasing research into the impact of postnatal depression on fathers and children. In the postnatal period and the ensuing months, more than at any other time, the infant will be in the mother’s presence. Murray et al (2003) and Stanley et al (2004) demonstrated the difference in gender interaction, cognitive development and stimulation between infants of depressed and non-depressed mothers. This research suggested that depression during the first few months of an infant’s life affected cognitive development of boys in particular. Some of the infants seemed unsure and insecure towards their mother and their behaviour was either boisterous or fussy. The studies showed this behaviour lasted for several years.

The studies also showed that if the quality of communication between the mother and her infant changed, as often happens when mothers are depressed, the infant may find it difficult to interact with her. The mother may be unable to smile and portray a look of pleasure on her face and, as a result, the infant becomes confused and is unsure how to respond to the mother’s gestures and facial expressions. During normal interactions infants learn that smiling in response to a mother’s smile is rewarded by another smile. However, if that smile is not reciprocated, infants become unsure of how to react. The situation need not be permanent and may be quickly remedied once the mother starts her recovery. The interactions of other family members also play a vital part as the regular exchange of smiles and gestures can help the infant to make sense of the world.

George (1996) found that half the male partners of women with postnatal depression also exhibited symptoms of depression or were clinically depressed. Some mothers blame their partners for the way they are feeling and their loss of libido. This area of research has highlighted the importance of communication and interaction with family members.

Risk factors
Risk factors for postnatal depression include:
- An unstable or unsupportive relationship;
- Anxiety during the pregnancy – where the mother has worried about her baby’s well-being;
- A previous history of sexual abuse;
- Poor role models, particularly from the mother’s own mother. There may have been separation in late childhood or her mother’s parenting skills may have been poor;
- A previous history of depression – previous postnatal depression or episodes of clinical depression;
- Increased obstetric intervention – problems during the delivery of the baby or admission to the special care baby unit.

Assessment
The Edinburgh Postnatal Depression Scale (EPDS) (Cox et al, 1987) is designed to assess depression at six to eight weeks and at six to eight months postnatally. Ideally, the mother is asked to complete the questionnaire at home, where a health visitor is present to ensure she can read and understand the questions. The questions ask about the mother’s mood, anxieties and general feelings during the previous seven days.

The final question asks whether the mother has thought of harming herself. Although a ‘yes’ may lead to discomfort for both parties, in most instances, the question encourages the mother to discuss any suicidal feelings she may have. Acknowledging this sometimes helps the mother to understand her

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Recent research suggests that early intervention, even in the antenatal period, is an effective way of tackling postnatal depression (Stuart et al, 2003).

Detecting a dysfunctional relationship between a pregnant mother and her partner during antenatal visits may alert the nurse or midwife to potential problems. A vulnerable mother may benefit from additional support from the health professional in the form of more regular visits to ensure she is able to address any anxieties.

The mother may be referred for psychological treatment to boost her self-esteem or encouraged to attend a support group. In each case the nurse is in a prime position to help, particularly if she or he is alerted to the possibility of postnatal depression and has the relevant knowledge base.

Most mothers benefit from talking about themselves, their problems and how they are feeling. Allowing them time to express their innermost thoughts can have a very therapeutic effect.

Holden et al (1989) stated that ‘listening visits’ by health visitors can be effective and this is supported by Seeley et al (1996). Several studies (Misri et al, 2004; Appleby et al, 1997) have also demonstrated the benefits of cognitive behavioural therapy where the mother is referred to a trained councillor or psychotherapist. The mother is encouraged to explore why she feels miserable and to examine how she might deal with her feelings in a constructive way, realise the effect they have had on her and prevent them from reoccurring.

Sometimes just being able to give time to mothers, either by listening to them or helping with their infant can be of great benefit. The nuclear and extended family should be encouraged to become more fully involved in the care of the infant. If family circumstances are conducive to this then the mother may be referred to either a statutory agency such as Sure Start or a voluntary agency such as Homestart. These organisations offer structured help and support and can provide volunteers to assist with everyday tasks in an effort to ease the burden on the new mother. If the mother is reluctant to seek help locally there are national voluntary agencies committed to providing practical solutions. They can offer a telephone listening service or put mothers in touch with more relevant organisations or with other mothers who have had similar experiences. It makes sense at this time for them not to take on any extra life-stressors, such as moving house or changing employment.

In some cases pharmaceutical interventions are necessary and may include the use of antidepressants. The most common are the selective serotonin reuptake inhibitors (SSRIs), which include fluoxetine (Prozac) and paroxetine (Seroxat). These effectively block the reuptake of serotonin at presynaptic neurons in the brain. This blockade enhances the activity of serotonin.

The serotonergic system modulates mood, emotion, sleep and appetite. It is significant in the control of numerous behavioural and physiological functions. Decreased serotonergic neurotransmission plays a key role in depressive symptoms. The drugs may take from two to six weeks or even longer to become fully effective and are prescribed when the risk from postnatal depression is greater than the risk from taking the medication. Long-term side-effects include insomnia, weight gain and sexual dysfunction.

Some general practitioners prefer to prescribe tricyclic antidepressants (TCAs) such as lofepramine or the older versions such as amitriptyline and imipramine (Hoffbrand et al, 2001). These prevent the reuptake of monoamines (serotonin or norepinephrine) by the presynaptic neurons in the central nervous system. By doing so, TCAs prolong the effects of the neurotransmitters.

The SSRIs are purported to be a safer medication, particularly for mothers who are likely to attempt suicide as they do not cause cardiotoxic effects and unlike TCAs are not generally fatal if taken in overdose. However, the most effective treatment involves the use of antidepressants, complemented by listening visits initiated by the health visitor, nurse or community psychiatric nurse (Misri et al, 2004).