# Postnatal disorders

**Postnatal depression - F53** (Closest equivalent clinical term: Neurotic depression of reactive type Eu204)

## Presenting complaints

Women may present with one of three distinct syndromes - in descending order of severity:

- Baby blues - normally occurs in the week after birth, and tends to be mild. Women with baby blues do not usually present, because the condition is short-lived, but it can develop into postnatal depression. A new mother presenting with depression should never be dismissed as having 'just the baby blues'.
- Postnatal depression - presents with mild/moderate to severe depression, usually 4-12 weeks after birth but may be up to six months after the birth.
- Puerperal psychosis - pronounced disturbance of mood, presenting in the first few weeks after birth.

## Diagnostic features

**Baby blues:**

- Emotional lability, crying, irritatability, tiredness, feelings of inadequacy.

**Postnatal depression:**

- tearfulness, which may be worse at particular times of the day
- irritability, agitation, poor concentration
- anxiety (the mother may be afraid to be alone with the baby)
- sleep difficulties (even if baby is sleeping)
- appetite disturbance
- guilt
- ambivalence about the baby
- low self-esteem, indecisiveness
- exhaustion and general inability to cope
- thoughts of self-harm and suicide
- vague physical symptoms.

Risk factors include a previous history of depression or postnatal depression, poor relationship with partner, adverse social circumstances, an unplanned pregnancy, perinatal death.

**Puerperal psychosis:**

- pronounced disturbance of mood - either consistently low or high, or fluctuating unpredictably between the two, and sometimes interspersed with periods of normal mental state
- extreme irritatability
- delusions (often taking the form of irrational preoccupations concerning the baby) and hallucinations
- onset within the first few weeks after birth.

Risk factors include a previous or family history of psychosis, and young age.

In different cultures, pregnancy and childbirth are associated with widely differing traditions and rituals, as well as differences in the concept of depression.

## Differential diagnosis and co-existing conditions

- Panic disorder - F41.0.
- Generalized anxiety - F41.1.

Depression following childbirth is essentially the same condition as depression at any other time.

There is a risk that normal physical or emotional changes following childbirth may be mistaken for depression or alternatively may mask depressive symptoms.

## Essential information for patient and family

- Baby blues affects up to 50% of new mothers and is usually self-limiting.
- Postnatal depression is common, affecting 10-15% of new mothers; puerperal psychosis is a much rarer condition (0.5-1% of all births).
- It can be very difficult for new mothers to admit that they are not coping or feeling depressed at a time they perceive should be happy.
- Mothers may be concerned that if they are honest about their feelings their baby will be taken into care.
- Mothers with postnatal depression do not usually harm their babies; babies may be at risk from mothers suffering from puerperal psychosis.
- Emotional and practical support from family and friends is very valuable (ref 204)
- The outcome for most mothers with postnatal depression is very good, provided they receive appropriate care.
- If untreated, postnatal depression may be prolonged and can have an effect on mother-baby attachment and in turn on the child's educational, emotional and behavioural experiences.

**References**

**204** Ray KL, Hodnett ED. Caregiver support for postpartum depression (Cochrane Review). In: The Cochrane Library, Issue 2, 2003. Oxford: Update Software. (CI) Women with postpartum (postnatal) depression who are supported by caregivers are less likely to remain depressed, although the most effective support from caregivers remains unknown.

## General management and advice to patient and family

**Postnatal depression:**

- The Edinburgh Postnatal Depression Scale (EPDS) is an effective tool for screening and monitoring progress; (ref 205) it is not a diagnostic tool.
- If available, non-directive counselling, interpersonal psychotherapy and cognitive behavioural therapy are effective (ref 206-208).
- Postnatal groups run by health visitors and mental health nurses are effective.
- Provision of social support, eg a home help or child care, may be helpful.

**Puerperal psychosis:**

- Very close monitoring of mother and baby is essential, which usually requires admission, preferably to a specialist unit.
- Medication is always required.
- Psychological therapies are likely to be helpful after the acute phase.
- Electroconvulsive therapy may occasionally be necessary..

**References**

**205** Harris B, Huckle P, Thomas R et al. The use of rating scales to identify postnatal depression. Br J Psychiatry 1989, 154: 813-817

**206** Appleby L, Warner R, Whitton A, Faragher B. A controlled study of fluoxetine and cognitive behavioural therapy in the treatment of postnatal depression. Br Med J 1997, 314: 932. (BII) Both fluoxetine and cognitive-behavioural counselling given as a course of therapy are effective treatments for non-psychotic depression in postnatal women. After an initial session of counselling, additional benefit results from either fluoxetine or further counselling

**207** Holden JM, Sagovsky R, Cox JL. Counselling in a general practice setting: a controlled study of health visitor intervention in treatment of postnatal depression. Br Med J 1989, 298: 223-6. (BII) Counselling by health visitors is valuable in managing non-psychotic postnatal depression.

**208** O'Hara M, Stuart S, Gorman L, Wenzel A. Efficacy of interpersonal psychotherapy for postnatal depression. Arch Gen Psychiatry 2000, 57: 1039-1045. (BII) Interpersonal psychotherapy is an efficacious treatment for postpartum depression. It reduced depressive symptoms and improved social adjustment, and represents an alternative to pharmacotherapy, particularly for women who are breastfeeding.

# Medication

- Antidepressants: the response in mothers suffering postnatal depression is usually good (ref 209). Antidepressants should continue to be taken for up to 6 months after recovery.
- SSRIs are the treatment of choice. Fluoxetine is contraindicated in breastfeeding mothers (BNF 4.3.3).
- Antipsychotic medication and mood stabilizers may be needed for puerperal psychosis.

**References**

**209** Hoffbrand S, Howard L, Crawley H. Antidepressant treatment for post-natal depression (Cochrane Review). In: The Cochrane Library, Issue 2, 2003. Oxford: Update Software Ltd (CI) One study was examined. Women with postnatal depression can be treated effectively with fluoxetine, which is as effective as a course of cognitive-behavioural counselling in the short-term.

# Referral

- Preconceptual referral is recommended for women:
  - with a history of bipolar disorder or other psychosis, including a previous puerperal episode, who have a high risk of puerperal psychosis
  - taking any mood stabilizers or long-term antipsychotics (ref 210)

- Refractory cases of depression should be referred to the community mental health team.

- In severe cases, referral to inpatient services may be necessary, ideally to a specialist mother and baby unit (babies should not be admitted to general psychiatric wards).

**References**

**210** Altshuler LL, Cohen L, Szuba MP et al. Pharmaceutical management of psychiatric illness during pregnancy. Am J Psychiatry 1996, 153: 592-606. (BI) This is a review. The use of psychotropic medications during pregnancy is appropriate in many clinical situations and should include thoughtful weighing of risk of prenatal exposure with risk of relapse following drug discontinuation.

## Resources for patients and families

**The Association for Post Natal Illness (APNI)** 020 7386 0868
Email: info@apni.org; website: http://www.apni.org
Provides information on postnatal depression. APNI will put affected mothers in touch with others who have had similar experiences.

**National Childbirth Trust (NCT)** 0870 444 8707
Website: http://www.nctpregnancyandbabycare.com
Provides information and support on all aspects of pregnancy and childbirth, with local groups around the country.

**Meet-a-Mum Association (MAMA**) 01525 217 064
Email: meet-a-mum.assoc@blueyonder.co.uk; website: http://website:www.MAMA.org.uk
Local self-help groups for pregnant women and those with young children.

**Fathers Direct** http://www.fathersdirect.com

**The Samaritans** 08457 909090 (helpline: 24-hour, everyday)
Email: jo@samaritans.org; website: http://www.samaritans.org.uk
Offer confidential emotional support to any person who is despairing or suicidal.

**Depression Alliance** http://www.depressionalliance.org
England: 020 8768 0123
Wales: 029 2069 2891 (10am-4pm Mon-Fri 10am - 4pm, Monday - Friday)
Scotland: 0131 467 3050
Provides information and self-help groups.

**Aware Defeat Depression Ltd** 02871 260 602
Email: info@aware-ni.org; website: http://www.aware-ni.org
Provides information leaflets, lectures and runs support groups for sufferers of depression and their relatives.
Leaflets are available from the Royal College of Psychiatrists (http://www.rcpsych.ac.uk):
Postnatal Depression - Help is at Hand, Mental Illness after Childbirth.

**Postnatal Depression: Facing the Paradox of Loss, Happiness and Motherhood** by Paula Nicholson. Wiley, 2001

**Maternal Distress and Postnatal Depression: The Myth of Madonna** by J Littlewood and N McHugh. Macmillan, 1997

**Coping with Postnatal Depression** by Fiona Marshall. Sheldon Press, SPCK Mail Order, 36 Steep Hill, Lincoln LN2 1LU, UK.