Postnatal Depression and Post-Traumatic Stress Disorder – an Update

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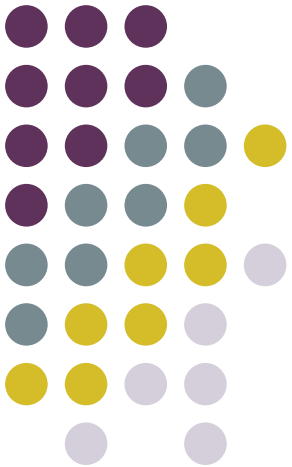
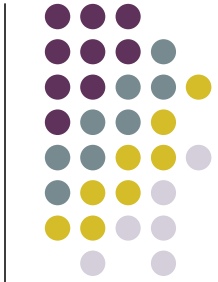


Today's presentation



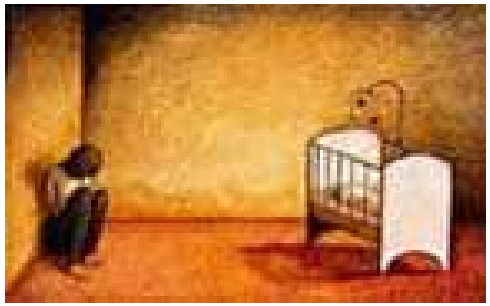
- Health after birth
- Postnatal mental health. Depression after birth and Post Traumatic Stress Disorder (PTSD)
- Can we prevent depression and PTSD after birth?
- Content and provision of care for women with mental health problems
- Future directions and Conclusion

Health After Birth

Health after birth

- Previously assumed women fully recovered from birth within 6 – 8 weeks
- Research during last decade has highlighted widespread and persistent morbidity
- Physical, psychological and psychiatric symptoms commonly experienced but frequently ‘hidden’
- Complex associations between physical health problems and psychiatric morbidity (Brown and Lumley 2000)
- Major public health issue. Suicide leading cause of maternal death in 12 months after birth (CEMACH 2004)
- Concerns that maternal mental health needs are unmet

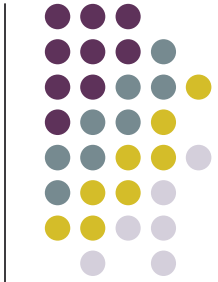
Postnatal Mental Health



Postnatal mental health

- Range of problems after birth; new, recurrent or ongoing
- Most common – transient psychological disorder ‘blues’. Tearful, overwhelmed, irritable. Usually passes with reassurance & support. Prevalence 50%
- Depression. Prevalence 5% - 28%. One meta-analysis of 59 studies showed prevalence of 13% (O’Hara and Swain 1996)
- Not confined to childbirth episode. 5% - 17% lifetime prevalence among general population (Kessler et al 1994)

Depression

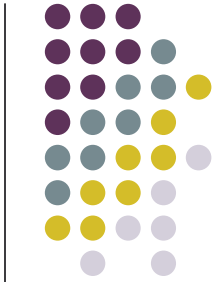


- Pregnancy and birth may increase risk
- Can have devastating impact on woman and child
- Symptoms may not be reported by the woman, or identified by health professionals
- Concern term ‘postnatal depression’ is not misused. Other conditions may be missed (CEMACH 2004). Diagnosis essential
- Variation in assessment and diagnostic criteria
- 2 diagnostic systems in use; DSM-IV & ICD 10
- Lack of consensus between criteria used

Major and Minor Depression. DSM-IV criteria

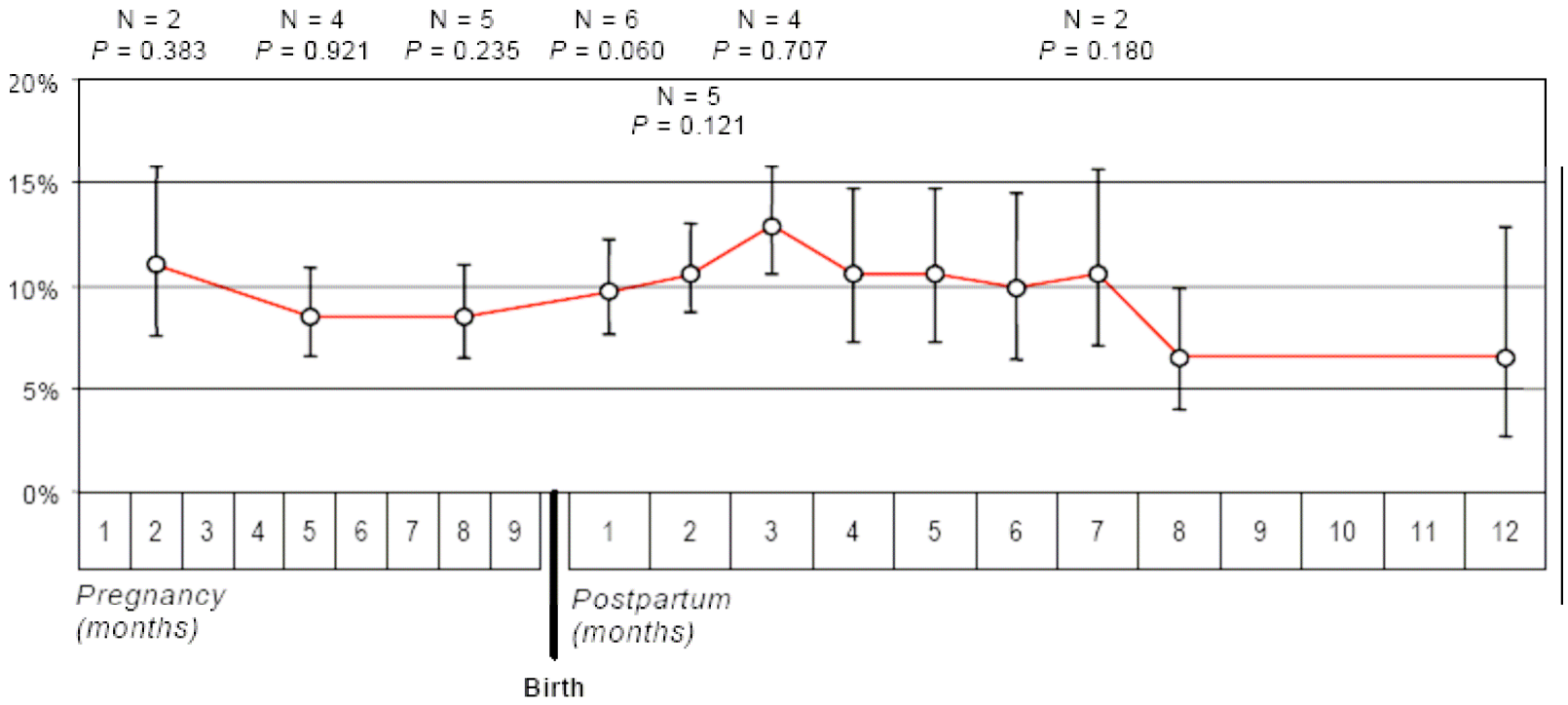
- Diagnostic Statistical Manual of the American Psychiatric Association
- Major: one or more episodes lasting for a least 2 weeks; daily disturbances in mood. At least 4 of the following symptoms (next slide!):
- Minor: one or more episodes of depression lasting 2 weeks or more with fewer symptoms than required for diagnosis of a major depressive disorder
- Postpartum occurrence defined as an episode within 4 weeks of giving birth

DSM-IV criteria



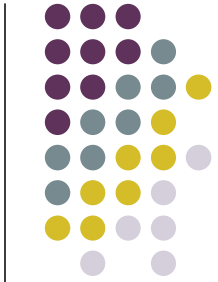
- Too much or too little sleep
- appetite or weight disturbance
- psychomotor agitation or retardation
- loss of energy
- feelings of worthlessness or excessive guilt
- problems with concentration or indecisiveness
- loss of interest in sex
- recurrent suicidal thoughts

Figure 9. Best estimates of point prevalence of major and minor depression



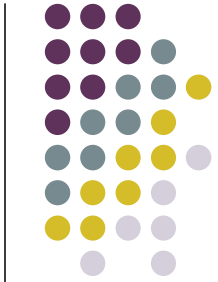
Agency for Health Care Research and Quality 2005; Evidence Report No: 119

Depression – Risk factors



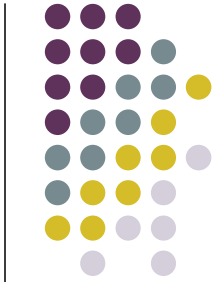
- Previous psychiatric history and low levels of social support frequently reported
- Demands of parenthood, family and social factors; marital and socio-economic status (Beck 2001)
- Biological factors; need to consider role of physical health problems (Brown and Lumley 2000)
- Recent life events
- Infant's general health

Psychosis



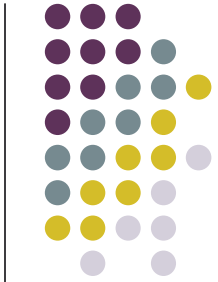
- Puerperal psychosis – most severe illness
- 1:500/1:1000 women
- Psychotic depression, mania, atypical psychosis, ideas of grandiosity
- Possibility of increased risk of self-harm or harming others

Psychosis – Risk factors



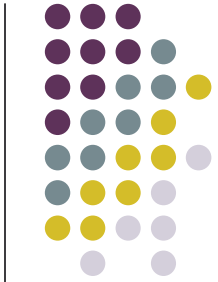
- Evidence limited (SIGN 2002)
- Pre-existing disorder – bi-polar disorder, schizophrenia
- Family history of affective psychosis in first or second degree relative
- Previous postnatal onset

Other conditions



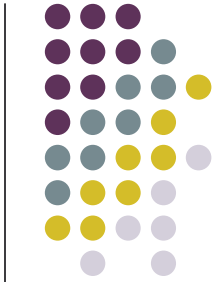
- Existing or recurrence of bi-polar disorder, schizophrenia (medication may be stopped, lack of postnatal planning/management, CEMACH 2004). Pregnancy may exacerbate symptoms.
- Anxiety disorders (panic disorder, generalised anxiety disorder, obsessive compulsive disorder, post traumatic stress disorder)

Post Traumatic Stress Disorder



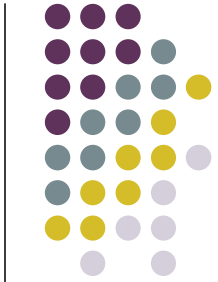
- PTSD associated with exposure to extreme events; combat, mass disasters, RTAs
- Anxiety disorder; re-experiencing the event; avoidance of reminders; hyperarousal
- Childbirth recognised as an event that can trigger PTSD (American Psychiatric Association); need to distinguish physical and psychological trauma
- For some women, experience of normal birth may include features which trigger stress reactions

Post Traumatic Stress Disorder



- Incidence based on case-reports, prospective studies; 1.5% - 6% (Ayers 2006).
- PTSD cases diagnosed using DSM-IV criteria

PTSD – Risk factors



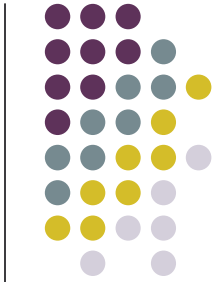
- Evidence limited
- Methodological issues. Robust large, longitudinal studies required to determine predictive factors
- Previous mental health problems
- High level of obstetric intervention
- Perception of limited control during labour
- Perceived low levels of support from partner, family, health care professionals

Can We Prevent Depression and PTSD After Birth?

Antenatal & Postnatal Interventions

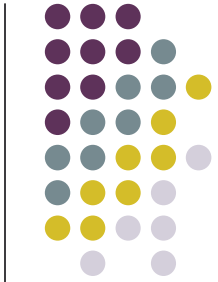
- Cochrane Library Review. Psychosocial and psychological interventions to prevent depression after birth (Dennis and Creedy, 2004)
- 15 trials. 7697 women (pregnant or up to 6 weeks postpartum)
- Insufficient evidence that diverse interventions will reduce number of women who develop depression
- Interventions with postnatal component only of more benefit; individually based interventions more effective than group

Can postnatal care be revised to reduce depression?



- Recent RCTs have assessed revisions to postnatal care provision and impact on maternal health
- Midwifery-managed maternity care (Turnbull et al 1996, Shields et al 1997)
- Early GP postnatal consultation (Gunn et al 1998)
- Postnatal support groups/booklets (Reid et al 2002)
- Community support workers (Morrell et al 2000)
- Midwifery-led postnatal care (MacArthur et al 2002, 2003). Only study to show positive effect on postnatal depression

Midwifery-led Postnatal Care



- Re-designed care associated with significant benefit to women's psychological health at 4 & 12 months postpartum (MacArthur et al 2002)
- No differences in physical health measure
- Women's views of care were either more positive or did not differ
- Unlikely to have major implications on midwifery workload
- Midwife views about care were more positive
- Consultations with GP during first 12 postpartum year were reduced
- Need to consider service provision in more detail

Postnatal screening for depression

- Important first step to identify those at risk of developing the condition; a symptom amenable to treatment
- Instrument has to have high sensitivity (‘true positives’) and specificity (‘true negatives’)
- Edinburgh Postnatal Depression Scale (Cox et al 1987)
- Used in a large number of research studies

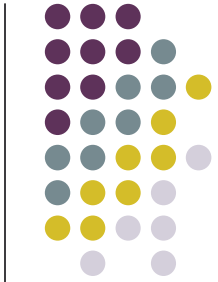
Postnatal screening for depression

- Studies have used a range of cut-off points to detect a ‘case’
- Different timings of screening; different populations; study inclusion criteria
- Data inconclusive as to scale sensitivity; many studies did not include follow-up diagnostic interview; criteria for minor or major depression
- UK National Screening Committee do not recommend use of the EPDS as a screening tool. Review in 2007

Postnatal screening for depression

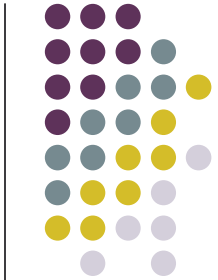
- Why?
- No evidence from RCTs that screening reduces mortality from depression. Limited evidence it reduces morbidity
- Insufficient evidence screening is acceptable to health care professionals or women
- No evidence screening would produce no harm
- No national plan for managing and monitoring a screening programme
- Lack of specialist services
- Can be used by those trained in its application to enable women to talk about their health – but cultural issues to consider

Prevention of PTSD



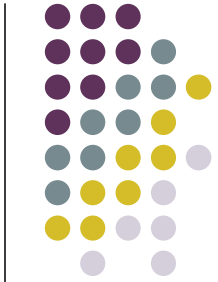
- Debriefing interventions introduced to reduce PTSD
- Structured psychological interview led by a skilled facilitator
- Explores experience, cognition, emotional reactions following a traumatic event
- Evidence does not support single session debriefing in the general population (Rose et al 2005)

Prevention of PTSD



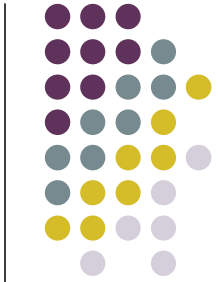
- Several RCTs have assessed outcomes following a postnatal debriefing intervention
- Lavender and Walkinshaw (1998). 120 women randomised following normal birth; interactive interview on p/n ward to explore feelings about the birth
- 3 weeks. Intervention group = lower anxiety and depression scores (using Hospital Anxiety and Depression Scale)
- Methodological issues; sample size & definition of high score; validation of scale; transient psychological symptoms

Prevention of PTSD



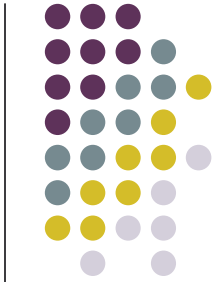
- Small et al (2000). RCT of women delivered by CS, forceps or vacuum extraction
- 1041 women. Intervention = interview with research midwife to talk about birth experience
- Intervention had worse health outcomes at 6 months (EPDS, physical, mental and social health status as assessed using SF36)
- 4 – 6 year follow-up of 534 women found no differences in outcomes; brief debriefing interventions = no proven effectiveness (Small et al 2006)

Prevention of PTSD



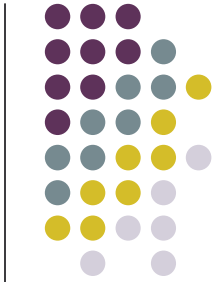
- Priest et al (2003). Single structured stress debriefing interview (15 minutes to 1 hour) within 96 hours of birth. Trained research midwife
- All modes of birth included
- EPDS, Impact of Event Scale at 2, 6, 12 months postpartum. Two weeks after each questionnaire, selected women interviewed by a psychologist
- 3 groups followed up. Selection based on EPDS scores >12; taking medication for psychological disorder; sample of women with low EPDS scores

Prevention of PTSD



- Primary study outcome; diagnosis of major depression, minor depression with depressed mood and functional impairment, PTSD within 12 months of birth
- No significant differences in any outcome measure at any follow-up
- Two-thirds of women rated debriefing session as helpful

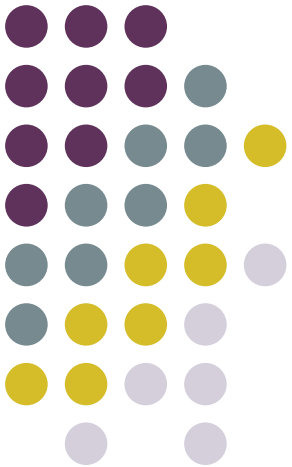
Midwifery debriefing interventions



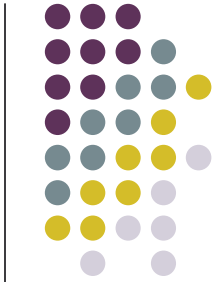
- ‘Debriefing’ interpreted broadly within the maternity services
- More often used to describe opportunity to talk about the birth
- Some confusion about the midwifery role (Alexander 1998)
- Majority of maternity units have formal or informal ‘debriefing’ services (Ayers et al 2006); variety of terms used to describe service provision
- Women do appear to value chance to talk about birth (NICE 2006)
- Cochrane review of debriefing in development (Bastos, Small, Bick and Rowan)

Content and provision of care for women with mental health problems

- Policy recommendations
- The views of women

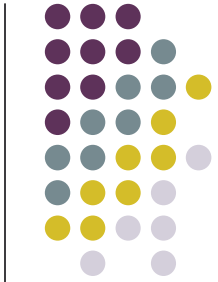


CEMACH recommendations (2004)



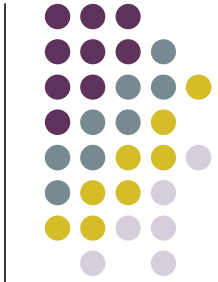
- Systematic enquiry about previous psychiatric history at antenatal booking visit
- Women with history of serious psychiatric disorder should be assessed antenatally by a psychiatrist and management plan put in place
- Guidelines should be in place in every NHS maternity unit
- Women should be advised about risks of recurrence of mental health illness following birth
- A specialist mental health team should be available
- Women who require psychiatric admission should be admitted to specialist unit with their infant
- Local training must be put in place before routine screening for serious mental illness is implemented

The views of women



- Women report neglect of emotional needs during the postnatal period (Singh and Newburn 2000, Beake et al 2005)
- MIND (2006) ‘Out of the blue. Motherhood and depression’ (Oates & Rothera)
- Survey of views of women experiencing perinatal ill-health; 148 women completed on-line questionnaire; in-depth interviews with some

The views of women

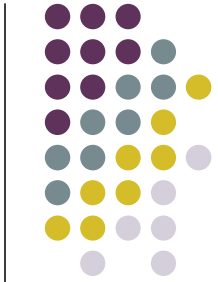


Key findings

- 90% attributed problems in obtaining care to lack of understanding by health professionals; inadequate advice and information
- Women most wanted information on how to recognise symptoms; half wanted information about common emotional changes & how and when to access services
- Important professional qualities were knowledge of mental illness around childbirth; ability to develop an understanding, trusting relationship
- Two thirds of women were placed on a general psychiatric ward; most were admitted without their baby
- 75% had medication for their problems; just over a third offered counselling
- Over two-thirds had to wait a month of more for treatment; one in ten had to wait over a year

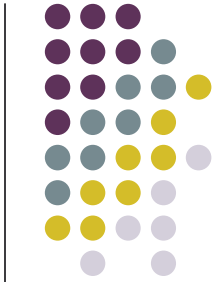
Future Directions and Conclusion

Future directions



- Need to address fragmentation of services for women with mental illness; gaps in communication; lack of referral pathways; lack of management plans; effective multidisciplinary working
- Need to address training needs of staff within the maternity services

Conclusion



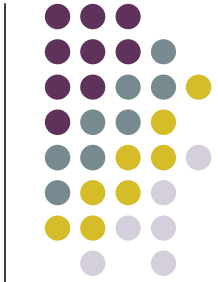
- Need to ask women about physical and psychological health; provide an opportunity to enable the woman to ask questions about her birth
- Cannot afford to ignore postnatal care; important role in early identification and referral of women with mental health needs
- Content and timing of care should be tailored to individual need (NICE 2006); identify those with no access to support
- Encourage mums to rest, advise on importance of good diet; importance of talking to others
- Should also consider the mental health of the father (Ramchandani et al 2005)

Antonia Ringbom, The
Lancet 2005; 365: 2159

Guidance for practice and service provision (www.nice.org.uk)

- Suite of NICE guidelines which cover screening, prevention, referral and management of mental health problems
- Published: Depression (2004); Anxiety (2004); Schizophrenia (2002); PTSD (2005), computerised cognitive behavioural therapy (2006), postnatal care (2006)
- In development: Intra-partum care; antenatal and postnatal mental health. Due to be published in 2007

Why this work is so important……..



'I sat in the park under a big tree, looking at the beautiful, clear, blue sky. There was no-one else there. Tears just kept coming out of my eyes and rolling down my cheeks, for no particular reason. I didn't feel particularly sad, but I just couldn't stop them.'

'Late one afternoon, I stood washing up at the kitchen sink. The water was hot. The next thing I remember is that the water was cold and it was dark outside. I was glad that we lived near King's Cross Station, because there were lots of trains and I could walk under one.'

Understanding Postnatal Depression. MIND. 2003