ARTICLE

Surviving postnatal depression

Rebecca Gillibrand reflects on the research in the light of her own experience

Reliable and easy detection tools have been created to diagnose postnatal depression, and yet many women suffering after the birth of their child do not receive the support they need.

This article examines the package of postnatal care available for new mothers including the role of medication, healthcare professionals' input and counselling.

question

Who do women turn to after the birth of their child?

resources

Muir, A. (2007). *Overcome your postnatal depression*. London: Hodder Arnold.
www.helpguide.org/mental/postpartum_depression.htm

I lost my baby. I didn't give her up for adoption; I didn't abandon her. I was simply unable to look after her, and she was cared for by her father. I suffered from terrible postnatal depression that wasn't diagnosed by a health professional. This postnatal depression lasted for many years and was aggravated by other psychological conditions.

I can recall one morning when I was feeding my baby and she was gazing up at me with clear blue eyes, I actually felt like thrusting the bottle into her. The feelings of guilt and horror were immediate. Another time she was crying in her cot and I could tell by her muffled sounds that the blanket must have risen and covered her face. My legs felt like lead as I tried to climb the stairs, each step taking longer and longer. I couldn't run and I only just got to her in time. Again the feelings of terror were immense.

When she was ill and I couldn't care for her because of my own intense feelings of anxiety; again I felt I was to blame. I lost two stone in one week and no one seemed to notice. Not long after that I suffered a nervous breakdown due to my increased symptoms of anxiety and inability to cope. This was my own diagnosis, as I did not receive assistance from a health professional at the time. In fact, I was never formally diagnosed with postnatal depression. My consequent research, degree in psychology and acquired knowledge allowed me to self-diagnose many years after the birth of my child.

I discovered that I had been displaying some of the most common symptoms of postnatal depression: guilt, feeling overwhelmed and unable to cope, panic attacks and a low mood for a long period of time (Wisner et al., 2002).

What should have been the happiest days of my life were the worst. I never had another child because of my experience. Fortunately, the bond between my daughter and myself is now steadfast despite everything, but I felt that my case highlighted the lack of recognition of the condition and support available. This occurred between the years of 1996 and 1998 but the effects were lasting – even today, I wonder if my condition has entirely gone. So what, if anything, has changed? Has the detection of postnatal depression and its management improved?

Definitions and prevalence

Postnatal depression can be broadly defined as non-psychotic depression occurring during the first six months postpartum (Howard, 2005). It is distinct from the 'baby blues': Muir (2007) proposes that up to 80 per cent of new mothers may experience baby blues, and the tears are of emotion rather than depression. A new mother can feel 'down' two to three days after the birth as the result of exhaustion and hormonal surges, and this can last a day or two. In terms of my own experience, in the first few days after the birth I found myself in floods of tears for no reason. Postnatal depression, however, is longer lasting and stronger in its effects. It can affect at least one in ten new mothers. Symptoms can vary in terms of how long a specific symptom may last and any changes that may take place along the course of the illness. Rare cases may involve puerperal psychosis, which differs in that contact with reality is lost after birth; delusions and hallucinations can be experienced (Sharma et al., 2004). Seeing a doctor immediately is imperative.

Beck (1998) categorises symptoms of postnatal depression to indicate areas such as anxiety, panic attacks, worrying thoughts, tension, irritability, aches and pains, sadness, sleeping difficulties,

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Lavender, T. & Walkinshaw, S.A. (1998). Can midwives reduce postpartum psychological morbidity? A

helplessness, appetite problems, guilt, shame, strange thoughts and loss of sex drive. The list is extensive, yet when you are in the midst of it you may not even recognise the symptoms as depression; I simply thought I was unable to cope with anxiety and the demands of my new baby. Easy and reliable detection procedures have been created, such as the Edinburgh Postnatal Depression Scale (EPDS) and the Postpartum Depression Screening Test (PDSS), yet primary care teams often still fail to diagnose it (Dennis et al., 2005).

It is somewhat absurd that despite the well-researched risk factors and detrimental health consequences for a postnatally depressed mother and her baby, such an illness still fails to be detected. Heneghan et al. (2000) discovered in a cross-sectional study of 214 women who brought their children to a general paediatric clinic, that 86 reported depressive symptoms on the Psychiatric Symptom Index. Unfortunately, of these women, only 29 per cent were identified as depressed by the paediatric healthcare providers. The study concluded that such healthcare professionals – paediatricians, paediatric trainees and nurse practitioners – needed to ask the mothers more direct questions about maternal functioning. They could also have benefited from using a structured screening tool designed to identify mothers most at risk for developing depressive symptoms.

However, we must not be too hasty to lay the blame with health professionals. Heneghan et al. (2000) found mothers to be reluctant to discuss parenting stress and depressive symptoms with their child's paediatrician because of fear of judgement and lack of trust. Indeed, a health visitor visited me in my home and suggested I may have postnatal depression, but she didn't follow it up and I was too ashamed and anxious to seek support for myself.

With this in mind, Morrell et al. (2010) developed the PoNDER trial (the POstNatal Depression Economical evaluation and Randomised trial). This involves training health visitors in cognitive behavioural techniques with a person-centred approach to assist mothers suffering from postnatal depression. The cluster randomised controlled trial revealed that training in identifying depressive symptoms and providing a psychologically informed intervention can positively benefit postnatally depressed women. This was the largest trial with regard to postnatal depression and health expert intervention. Understanding of this package of postnatal care is relevant to health visitors, nurses, counsellors and psychologists alike.

Postnatal depression can affect at least one in ten new mothers

Many of my symptoms were anxiety-related more than depression, and I considered this to mean that I wasn't suffering postnatal depression. Though a suitable questionnaire would have suggested such a diagnosis, provided an experienced clinician was able to assess for postpartum anxiety (Tuohy & McVey, 2010), it is a reminder that women should be supported whatever their symptoms may be after childbirth. If there were more of an awareness of the uniqueness of postnatal depression, perhaps more women would come forward for help.

The use of medication

There are several strategies for the management of postnatal illness that can support the patient. This is essential, for if the illness is left alone, it may be more prolonged with a detrimental effect on the relationship between mother and baby as well as on the child's subsequent cognitive and emotional development.

Hoffbrand et al. (2001) set out to evaluate the effectiveness of different antidepressant drugs on the postnatally depressed mother, as well as to compare their effectiveness with other forms of treatment. The data was found to be inconclusive, needing more trials with larger sample sizes as well as longer follow-up periods in which to be able to compare the effects of different antidepressants with psychosocial interventions.

However, Appleby et al. (1997) used a randomised controlled treatment trial, with four treatment cells involving fluoxetine or placebo as well as one or six sessions of counselling with postnatally depressed women six to eight weeks after childbirth. The results indicated an improvement in mothers receiving the antidepressant, which was significantly greater than those receiving the placebo. There was also improvement after six sessions of counselling significantly greater than a single session of counselling. However, there was no interaction found between medication and counselling.

Do mothers understand the importance of medication to treat their

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symptoms? Chabrol et al. (2004) researched mother's opinions of antidepressants, questioning 405 women admitted in obstetric clinics. Before mothers received information about the present knowledge on antidepressant treatment, the acceptability of antidepressants was significantly lower than psychotherapy. After information was given to the mothers, such as the effect of medication on breast milk, mothers accepted the possibility of taking antidepressants even less. This highlights the concerns surrounding medication used for postnatal depression, not only with health professionals but with mothers too.

The role of health professionals

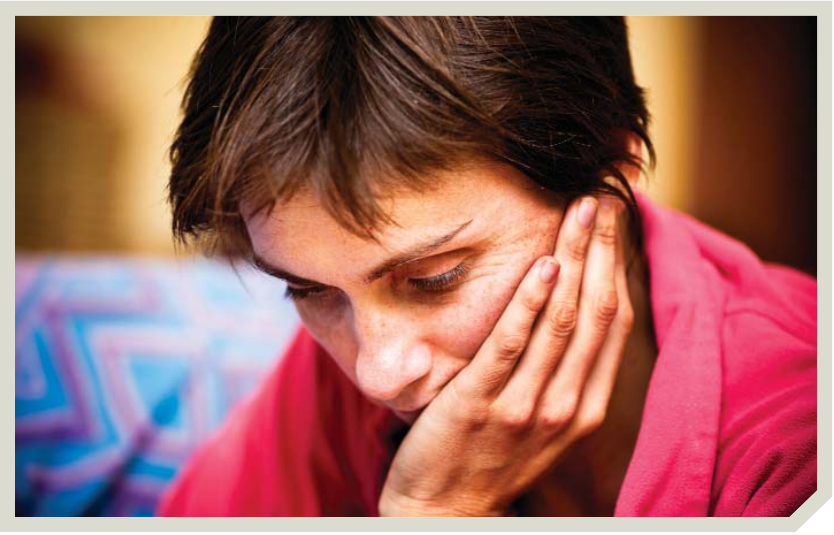
Counselling, a systematic process that offers individuals a chance to explore and discover ways of living with a greater sense of well-being, has been evaluated in studies. Systematic intervention that is non-directive in nature (based on supportive listening without giving advice), of around six to eight sessions delivered by primary healthcare workers such as health visitors, has been found to more effective than routine care in reducing mothers' postnatal depression after having a baby (Cooper & Murray, 1997). Plews et al. (2005) insist that health visitors are in the ideal position to be able to help mothers with postnatal depression. It has also been found that midwives giving counselling and support, as well as explanations about childbirth prior to labour, improve the mental health of mothers (Lavender & Walkinshaw, 1998).

Others have concluded that health visitors can be trained in the detection and management of postnatal depression, as well as difficulties with the mother–child relationship, and as a result can provide an intervention that benefits depressed mothers. Seeley et al. (1996) compared two groups of women with postpartum depression. They analysed the results from the EPDS as well as the mothers' perceptions of infant behaviour and their relationship with their infant. The group that received health visitor intervention had their difficulties reduced by half, while for the control group the high rate of problems with their child did not reduce from six weeks to four months postpartum. However, the study did have methodological flaws in that the groups were unmatched and the researchers employed a non-standardised questionnaire with regard to the perception of infant behaviour and relationship.

There is other research illustrating the positive outcome for midwifery-led care that is focused on individual women's physical and psychological health needs. MacArthur et al. (2003) looked at 36 randomly selected general practice clusters in the West Midlands Health Region. Midwives recruited 1087 women in the intervention and 977 in the control practice clusters. The researchers compared normal practice with the redesigned community postnatal care led by midwives. This involved screening tests and symptom checklists used at various times in the postnatal period, individual care and visit plans based on needs as well as care delivered over a longer period. The results showed this redesigned care to be very beneficial for the postnatal mothers. There was an improvement in women's emotional health in comparison to current care at four months postpartum, which persisted at 12 months.

The research evidence therefore suggests that health professionals such as midwives and health visitors may be in the best position to offer mothers the emotional support and care that is needed. A mother may feel more able to confide in a health professional as she is more likely to have a trusting relationship with such an expert, particularly if she has known her midwife or health visitor throughout her pregnancy.

I wish I'd had a health professional to talk to. Instead I was left isolated with only my family to attempt to support me.



Stigma and myths do still exist, preventing a depressed mother from recognising her own symptoms

Emerging from the shadows

My reading of the research suggests that the evidence base with regard to detecting postnatal depression and treating it effectively is growing. But perhaps not much has altered since I had my daughter: as Dennis (2005) notes in her systematic review, there is a combination of problems occurring. Women feel unable to disclose how they feel, and this is not helped by family and health professionals being reluctant to respond to their emotional needs. Stigma and myths do still exist, preventing a depressed mother from recognising her own symptoms and thus allowing her condition to deteriorate further and detrimentally affect her life. However, this 'ignorance' is reducing, with celebrities now coming forward to say what they have suffered after having their children.

I advocate further awareness and knowledge of this topic, to allow it to emerge from the shadows. We need to reduce the feelings of shame and worthlessness that such mothers commonly experience. Education and training for health professionals is urgently required and once this is more firmly in place, perhaps women who suffer from postnatal depression will become more proactive in seeking help. Hopefully then many new mothers will be saved from this enduring illness and truly enjoy the experience of motherhood.

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