Post natal depression – role of the practice nurse

Approximately 13% of mothers experience PND. It occurs at a crucial time in a mother's life, can persist for long periods and have adverse effects on partners and on the emotional and cognitive development of the child.

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Postnatal depression (PND) is a significant public health issue, occurring during the perinatal period which is a time of intense change and transition for women. Detection of and intervention in PND is crucial to the well-being of mothers, their infants, partners and families.

Becoming a mother is a significant developmental transition, and a woman's adaptiveness involves her biopsychosocial being, family and the society in which she lives. First-time mothers are faced with the demands of learning new skills relating to infant care practices and recovering physically and emotionally from child birth. This transition is a process of personal and interpersonal change as a woman assumes maternal tasks and appraises herself as a mother.[1] During this transitional period, mothers are presented with the challenge of simultaneously providing self-care and infant care while in the hospital and then mastering these skills at home, often in an unsupported environment.

The focus of this paper is to present a discussion on issues related to PND. The concept of PND is discussed in the context of prevalence and definition which is followed by an outline of the symptoms experienced by mothers. Identification and screening of PND is a crucial step in dealing with this significant problem for new mothers and is considered together with the NICE guidelines. Finally, the treatments for PND are outlined. Irish research on social support and first-time mothers is discussed in relation to their mental health and well-being.

Concept of PND

Ascertaining the combined period prevalence of PND and minor depressive disorders is estimated to be between 5% and 25%. This wide variation in prevalence rates indicates inherent difficulty in estimating them and is at least partly due to the many ways in which it is defined. The World Health Organisation and the American Psychiatric Association define it as being similar to general depression with the exception of the timescale, which is limited to 4-6 weeks postpartum. Several longitudinal and epidemiological studies have yielded varying prevalence rates, however a meta-analysis of 59 studies reported a prevalence of 13%, with most cases starting in the first three months postpartum.[2] Internationally, prevalence rates vary across and within countries, ranging from as low as 4.4% at 12 months to as high as 73.7%.[3] Prevalence rates reported from Ireland have also varied from 11.4% to 28.6% [4] with the most recent study reporting prevalence rates of 13% at 6 weeks and 10% at 12 weeks.[5] There may be many reasons for this variation which include: using different screening assessments, using varying cut-off scores (11-13) on the Edinburgh Postnatal Depression Scale (EPDS),[6] assorted timescales (6-12 weeks postpartum) and different samples. For example one study included a high representation of a sample of mothers with a previous history of depression.[7] This morbidity has well documented health consequences for the mother, child, and family. Women who have PND are significantly more likely to experience future episodes of depression and infants and children are particularly vulnerable because of impaired maternal-infant interactions and significant cognitive and emotional development.[8] The nature and symptoms of postnatal depression are characterised by tearfulness, fatigue, anxiety, despondency and excessive anxiety over the baby.[6]

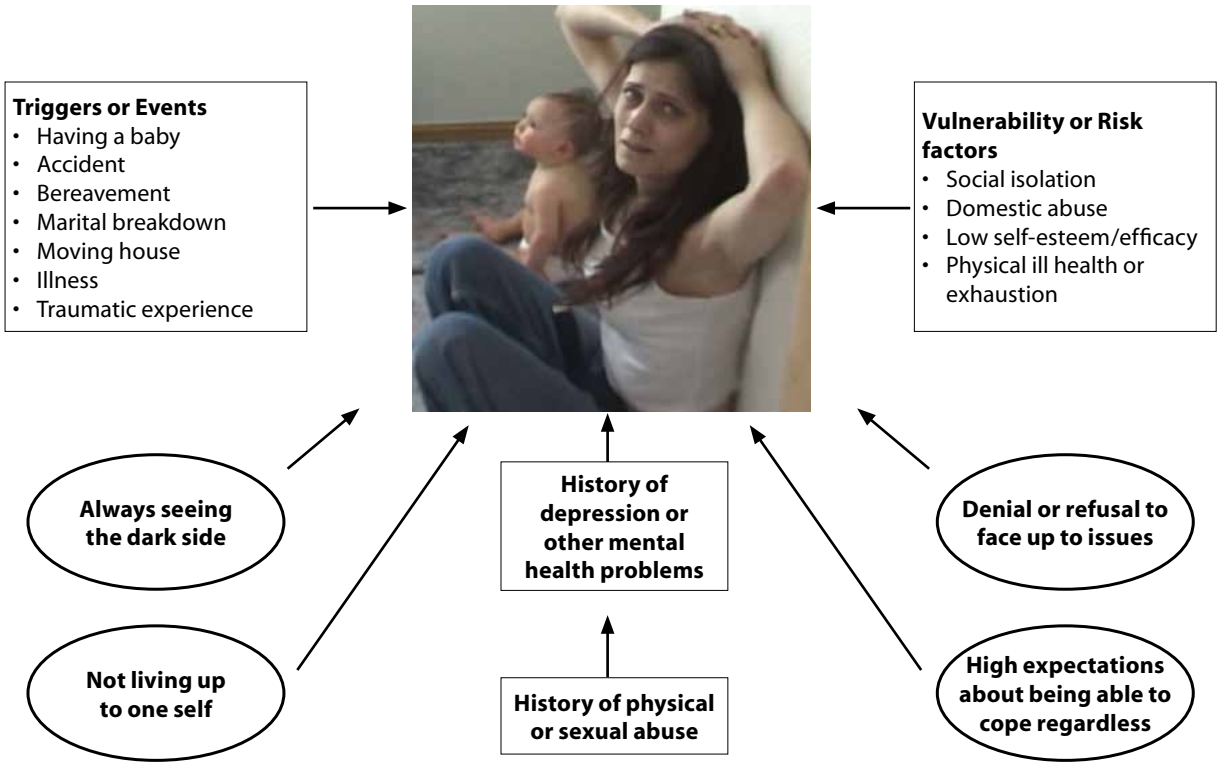

Figure 1. Bio Psychosocial Explanations of Depression
Cited from Nicolson, P (1988) Postnatal Depression Facing the paradox of loss, happiness and motherhood p. 13 Wiley, Sussex.

Causes and symptoms

The cause of postnatal depression remains unclear; however, extensive research suggests many contributory factors. The importance of psychosocial, psychopathology and psychological risk factors have consistently been identified in the epidemiological studies and meta-analyses conducted. The strongest predictors include: past history of psychological disturbance, stress, marital conflict, low maternal self-efficacy (confidence) and poor social support. In addition, indicators of low social status showed a small but significant predictive relation to PND.[2,9] The bio-psychosocial model outlined in Figure1 demonstrates the complexity of depression and hence the difficulties in identifying the cause.[10] Identification of PND for postnatal mothers is essential both for the mother and for her infant's health and wellbeing. Therefore, it is necessary for healthcare professionals to recognise and acknowledge the experiences of mothers with PND.

A number of qualitative studies have been undertaken internationally to gain a greater and deeper understanding of what the experiences are from mothers' perspectives.[11, 12, 13, 14, 15,16] These studies depict the following feelings and experiences of mothers with postnatal depression: loneliness, hopelessness, anxiety, confusion, poor concentration, guilt and fatigue. From an empirical perspective mothers' descriptions of PND also include elements of loss such as, loss of control or loss of former identity. Consequently PND differs from general depression, not only in timeframe, but also in the context of role transition, including loss of familiarity and thus, loss of control and the need to feel normal. This rich data provides us with an understanding of what it is like for mothers living with PND.

Practice nurses will meet mothers and their new infant, frequently accompanied by their partner, when they attend their GP for the 2 week baby check-up. This first visit to the GP is an ideal opportunity to assess the mother's physical and psychological health and well-being.

Practice nurses can contribute by fostering emotional support from significant others within mothers' social network.

Risk identification

Identifying women at risk for pos PND and providing early treatment interventions are the first steps in dealing with this problem. Although a number of tools (essentially self-report questionnaires) have been developed for the detection of depression, only eight studies assess their use in the postnatal period. Only one of these, the Edinburgh Post Depression Scale,[6] has been used in a sufficient number of studies to make a judgement on its usefulness. However, these studies have a number of limitations including: small sample size, high prevalence of depression amongst the included studies and many were undertaken in a research rather than a clinical setting. There has been much debate in the literature as to the suitability of using the EPDS in clinical practice for screening for PND. This reluctance is primarily related to the EPDS having reasonable sensitivity but lower specificity and thus positive predictive value is poor. This means that many women who do not have PND are being told of the possibility that they have the condition and are then subject to further investigation, placing an increased and wasteful burden on resources. Similarly, the two Whooley[17] questions plus the additional

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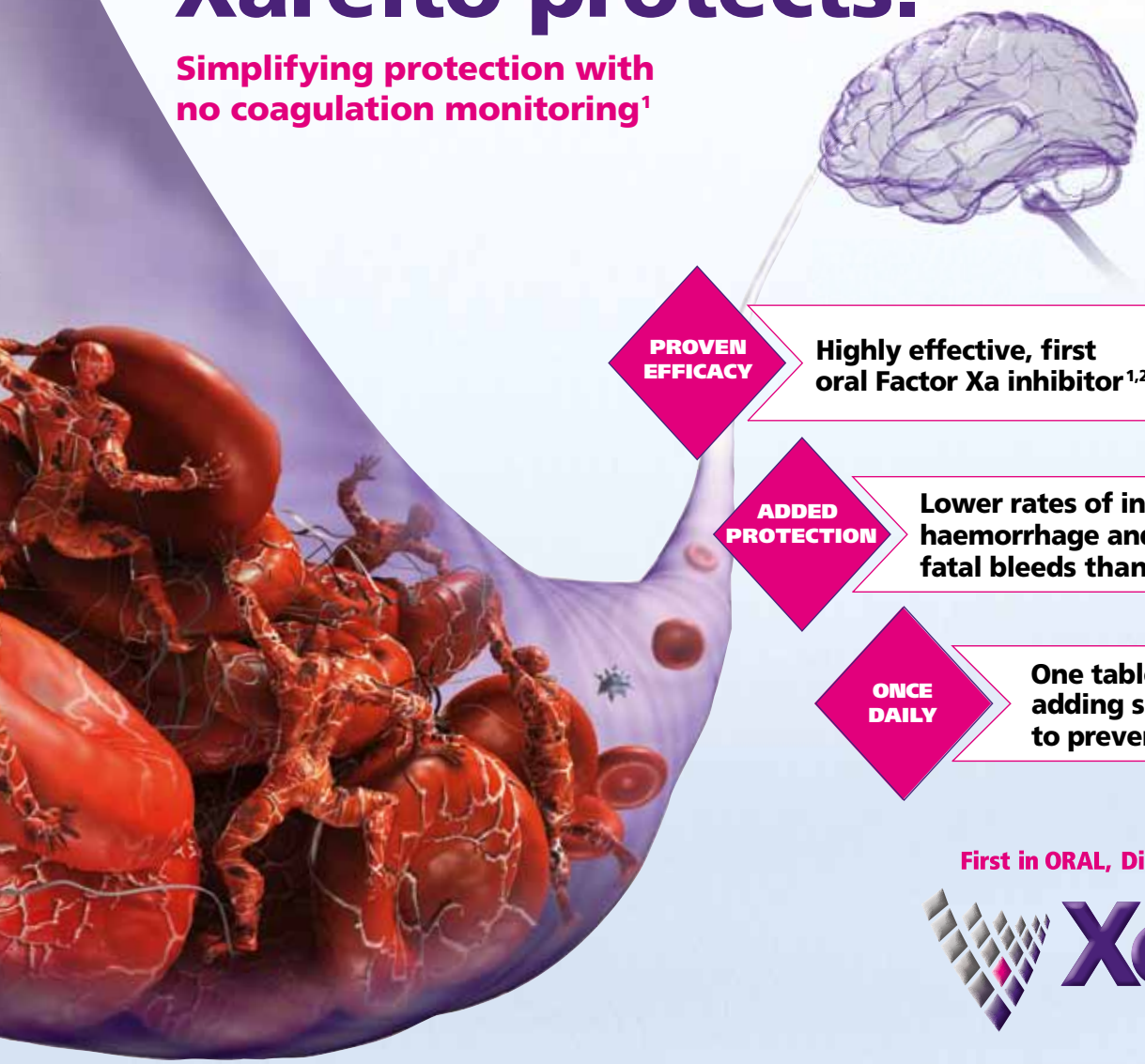

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L.IE.GM.06.2012.0006 Date of Preparation: 06/2012.

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Arroll question (Table 1) have poor positive predictive value. Nonetheless, the Current NICE guidelines[18] recommend using them. Although little specific evidence exists for their use in the perinatal period, their ease of use and reasonable sensitivity and specificity, particularly if combined with the additional help question from Arroll et al.[19] suggest that their use in routine care may be practical and acceptable. The questions (Table 1) are simple screening methods which can detect postnatal depression and lead to a subsequent referral for a full clinical assessment follow-up. This screening technique is an opportunity to screen without the need for a more formal assessment. Practice nurses and public health nurses have the most contact with mothers in the postpartum period and therefore are in a prime position to assess for PND and provide support.

Treatment

Treatments for PND are variable depending on the severity and a mother's preferences. Treatments include antidepressants, psychotherapy, support, or a combination of these. Evidence-based treatments include antidepressants cognitive behavioural counselling (CBC), cognitive behaviour therapy (CBT), psychodynamic therapy and supportive counselling either in the home, as a member of a group or telephone contact.[4] Combined approaches involving psychopharmacology and psychotherapy using a holistic approach with mothers in the context of the broader socio-political climate have been demonstrated as effective.[4] Social support has also been identified in a number of studies to contribute positively to the transition to motherhood and more specifically to postnatal depression.

Social support

International and national policy documents suggest that support is necessary for maternal and infant well-being and facilitates women's adaptation to motherhood. In previous research, mothers in the postnatal period have reported that help received from their partners and mothers, both with household chores and infant care, to be of great importance to them. Providing support for mothers in caring for their infants in the postnatal period is an important concern for nurses in the community, because research has shown that social support can facilitate women's transition to motherhood.[20] Furthermore, previous research has indicated that social support from partners, maternal mothers and peers,[21] and home visits from nurses[22] have reduced postnatal depressive symptoms.

Within the Irish context, given the importance of social support in facilitating transition to motherhood, Leahy-Warren[23] conducted research with first-time mothers (n=99) exploring the relationship between social support and confidence in infant care practices at 6 weeks postpartum. Findings revealed that support in the guise of mothers' receiving positive affirmation with caring for their infant had a significant influence in their confidence. Mothers revealed that the sources of this type of support were their partner and

Table 1 The Whooley questions

As per the NICE guidelines (2007) – at a woman's first contact with primary care, both at her booking visit and first visit postnatally, healthcare professionals including nurses, midwives, public health nurses or GPs should ask two questions to identify possible depression. The Whooley questions are derived from research (Whooley, Avins, Miranda, 1997) which indicate that directed questions are as sensitive in case finding for postnatal depression as more detailed techniques.

The questions are:

1. 'During the last month, have you often been bothered by feeling down, depressed or hopeless?'
2. 'During the last month have you often been bothered by having little interest or pleasure in doing things?' (NICE CG 45)

   This is also supplemented with a third question if the answer to either of the first two is 'Yes':
3. 'Is this something with which you would like help?' which has three possible responses: 'No,' 'Yes, but not today,' and 'Yes.'

   (Arroll, Goodyear-Smith, Kerse, N., et al.2005).

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Arroll, B., Goodyear-Smith, F., Kerse, N., et al. (2005) Effect of the addition of a 'help' question to two screening questions on specificity for diagnosis of depression in general practice: diagnostic validity study. British Medical Journal, vol 331, p 884

National Institute for Health and Clinical Excellence (2007) Antenatal and postnatal mental health: clinical management and service guidance (NICE CG 45) (para 5.4.3 p116).

Whooley, M. A., Avins, A. L., Miranda, J., et al. (1997) Case-finding instruments for depression. Two questions are as good as many. Journal of General Internal Medicine, vol 12, pp 439–445

mother. Results also showed that public health nurses and their own mother were the primary source of informational support. Therefore, it is essential that nurses facilitate the identification of individual mother's sources of support and continue to provide them with information that is relevant and appropriate.

A more recent Irish study examined the relationship between postnatal depression, maternal parental self-efficacy (confidence) and postnatal depression during the first 3 months postpartum with a large sample of first-time mothers (n= 512).[5, 24] The results showed that at 6 weeks, significant relationships were found between functional social support and PND and informal social support and PND. This means that support received from a mother's partner, own mother, family and friends positively influenced pos PND symptoms at 6 weeks. The types of supports that were significant were informational, instrumental (hands-on help), emotional (caring) and appraisal (positive affirmation). Findings also revealed that the higher the level of maternal/parental self-efficacy (confidence) the lower the level of depressive symptoms. This means that mothers who have confidence in their own ability to care for their infants are less likely to have PND symptoms. Nurses need to be aware of and acknowledge the significant contribution of social support, particularly from family and friends in positively influencing the mental health and well-being of first-time mothers.

The best predictors of PND at 12 weeks were at-birth professional support and emotional support. What this means is that mothers who received low levels of professional support at birth were 3.24 times more at risk of PND at 12 weeks than mothers who received high levels. Furthermore, there was an elevated risk (2.92 times) of PND at 12 weeks in mothers with low emotional support, compared with those who received high emotional support at birth.[5, 24] These findings signify the need for nurses to be mindful of the importance of supporting mothers in the early postnatal period. Practice nurses can contribute by fostering emotional support from significant others within mothers' social network.

Conclusion

Postnatal depression is a serious public health issue and can have devastating consequences for mothers, partners, infants and their families. Early identification and appropriate intervention is crucial in dealing with this condition and practice nurses are in an ideal position to facilitate this. Furthermore, nurses are well placed to mobilise social support for new mothers and encourage their partners and mothers to provide all types of support throughout pregnancy, delivery and the postpartum period.

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