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Judith Lumley

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Attempts to prevent postnatal depression

*Interventions have not included mental health workers, and have failed*

A systematic review published in this week’s BMJ concludes that the many psychosocial or psychological interventions tested so far in trials do not effectively prevent postnatal depression. Because this is an important disorder arising from around one in eight births, the authors call for more research on intensive support at home in the postnatal period. As little as 20 years ago, however, there was debate about whether postnatal depression was an important problem at all. It was too often dismissed as only a minor, transient problem with coping. So what happened in the meantime to warrant these trials of possible prevention?

In 1989 the prevalence of depression among women eight months after birth in population based surveys in Victoria, Australia, was 15.4% (95%
Confidence interval 12.8% to 18.0%)\(^2\) and two subsequent studies found very similar prevalences and confidence intervals.\(^3\) Depression was defined in these studies as a score of ≥15 on the Edinburgh postnatal depression scale; a score of 10-12 out of a possible total score of 50 is sometimes used as the threshold for detecting depression (or possible depression when there is no confirmatory clinical diagnosis).\(^6\)

The response of an anonymous obstetrician to the 1989 findings was highly critical: “Severe postnatal depression occurs in very few women (probably only 5 in every 1000 delivered) but minor problems in psychiatric condition are seen in many women during the first weeks after the birth of a child as they learn to cope with a new baby and all its demands, along with all of the demands of living in the 1980s and 1990s. To imply that the vast majority of these women have postnatal depression is surely a fabrication of the truth.”\(^7\)

A follow-up study of the first survey\(^8\) found that almost a third of the women scoring as depressed (or, strictly speaking, probably depressed) at eight months were still depressed, or were depressed again, 12 to 18 months later.\(^9\) Only 15% of the women defined as depressed had sought help from, or been referred to, any mental health professional. The lack of referral to mental health practitioners was striking.

It is not surprising that many of the women who scored as depressed in that survey but were not referred also rejected the term “postnatal depression,” although not on the grounds that problems they had after their babies’ births were minor and transient. When interviewed they agreed that they were depressed but saw this as “depression” rather than “postnatal depression.” The term postnatal depression implied to them, unacceptably, that their feelings were caused by their babies. One woman said: “The way I have felt has been due to problems with my estranged husband, not the baby.” Another wrote: “Answers are not due to postnatal depression. My baby, now 8 months, was operated on at 11 weeks and suffers from asthma and apnoea attacks so I have had a hectic few months.” Others rejected the term because they considered postnatal depression to be a severe psychiatric illness that came without warning, out of nowhere.\(^10\) This was the context in which the earliest studies included in the systematic review were designed.

As a coauthor of two of the included trials,\(^11\) I can say confidently that the rationale for developing them was not a strong belief that the interventions were likely to be highly effective in reducing maternal depression after birth but a concern that some specific interventions (midwife led postnatal “debriefing” in the United Kingdom and an early postnatal check by the general practitioner in Australia) were already under way or were about to be implemented widely without any evidence of effectiveness. Both interventions seemed feasible, both had support from the relevant practitioners, and neither was seen to require additional staff or major retraining.

The postnatal interventions in the other two UK trials designed at the same time\(^12\) clearly required additional resources but the interventions themselves—additional practical support at home for mothers in one and an information package with or without mothers’ groups in the other—\(^13\)—had been widely discussed in the previous five years and again had substantial support from practitioners, although none were able to reduce maternal depression after birth. The antenatal trials were also ineffective, but their low participation rates suggest that those interventions may have been too time consuming for pregnant women. The trial of MacArthur et al stands alone in terms of effectiveness.\(^14\) It was also firmly located within UK patterns of maternity care although this, unfortunately, makes its findings difficult to extrapolate to other models of postnatal maternity care.

What seems strange, when contemplating these trials 10 years after they were planned, is the apparent lack of involvement by mental health practitioners in the design of the postnatal trials. Could there be a link between the lack of input from the mental health field, inadequate understanding of evidence on mental health, and the lack of effectiveness of the interventions?

Work on reducing other important and common health problems in populations—such as smoking, road deaths, and cardiovascular disease\(^1\) —shows that a shared understanding and belief about the key risks and possibilities for prevention is crucial. The absence of mental health practitioners and researchers from many of the trials of prevention in postnatal depression is a sign that a shared understanding is still some distance away.\(^15\) Closing that gap may be a prerequisite for planning more effective interventions.

Judith Lumley director, mother and child health research unit
La Trobe University, Carlton, VIC 3053, Australia
(j.lumley@latrobe.edu.au)

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