Is it possible to predict postnatal depression? Research into the origin of blues and depression. The role of the gynaecologist

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Summary

Purpose of investigation: the authors investigated the role of the gynaecologist in trying to predict postnatal depression. Women suffering from postnatal depression (PND) are the expression of a failure to adapt to the unjust demands that society makes on them. Isolation and the lack of social support during and after the pregnancy are very strong factors of risk for postpartum depression.

The problem is serious and it develops rapidly, within two weeks of childbirth. It requires immediate and continuous treatment. There is also some risk of infanticide or suicide.

Methods: submission of a questionnaire based on the EPDS (Edinburgh Postnatal Depression Scale) to 222 pregnant women between 28 and 40 weeks of gestation.

Results: 28.4% of the patients resulted positive to the test (score > 12 points) and the hypothesis would seem to be that there is a continuum between depression suffered pre- and postpartum, and that the depression begins during pregnancy and then becomes more acute or less latent at the time of confinement.

Conclusions: the gynaecologist must have a role in helping to achieve an early diagnosis of the depression, because the earlier the problem is recognised the greater are the possibilities of therapy and preventing any consequences for the entire family group.

Key words: Postnatal depression; EPDS; Prevention; Early diagnosis.

Introduction

The birth of a child is an event full of intense emotions. It causes numerous changes in the relations between the couple and in the woman herself, since it modifies a series of equilibria in the family, and thus it leads to a radical restructuring of marital relations. This crisis is more evident in the woman, who undergoes rapid and evident transformations of her body: because of this the woman has to face up to reality and the expectations that her surroundings offer and reserve for the future, and thus condition her state of mind. During her pregnancy every mother creates a mental image of the child of her hopes, her fears and her dreams. This however is a baby that exists in the depths of the mother's mind and thus birth brings with it a moment of crisis, since the real baby can turn out to be extraneous if compared with the baby of fantasy. Stern *et al.* [1] state that "there is a baby in your arms and there is another in your imagination, and they rarely coincide perfectly". According to Romiti [2], women suffering from postnatal depression (PND) are the expression of a failure to adapt to the unjust demands that society makes on them. Isolation and lack of social support during and after the pregnancy are very strong risk factors for postpartum depression [3, 4].

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The disturbances met with can be described as follows:

Maternity blues: days of crying characterised by temporary bad temper, confusion, crying without reason and emotional instability, unleashed by the drastic hormone changes and by a totally new situation. This is quite evident in the 3rd or 4th day after childbirth, but it may continue during the first two weeks after birth [5, 6].

There are many reasons for the blues phenomenon:

– some believe that it is a normal emotional reaction to a stressful event such as childbirth [7];

– endocrine modifications following childbirth [8];

– prior emotional instability, the difficulty in accepting the baby as an internal object, the perception of the passive role during the birth and confinement due to hospitalisation [9, 10].

Postnatal depression: similar to clinical depression, characterized by a sense of fatigue, sadness, discouragement, incapacity to face the tasks of daily life. It appears during the first six months after childbirth and it may last for weeks or even months, such as to require immediate hospitalisation and treatment with anti-depressives or by psychotherapy.

Puerperal psychosis: rather rare, characterized by fits of delirium, loss of reason, hallucinations and exaggerated anxiety, with depressive and maniacal clinical aspects and even forms of schizophrenia.

The problem is serious and it develops rapidly, within two weeks of childbirth. It requires immediate and continuous treatment. There is also some risk of infanticide or

suicide. In clinical experience and in many publications the first 12 months after childbirth are considered to be the period in which depressive symptoms may develop [11].

What is the role of the gynaecologist in preventing PND? Not only does the gynaecologist follow the mother during the entire pregnancy, but he or she is also the person who interacts with the mother in the first three to four days after the birth. Specific signs of risk for the development of PND can be recognised and which mothers are at risk can be ascertained. However depression is often not immediately recognised, due to its slow and insidious development. Many women tend to hide their symptoms and only a minority seek the help of a professional to obtain prompt action to reduce emotional suffering and limit the consequences that this pathology could have on the baby and the family.

Materials and Methods

The study carried out at the Department of Gynaecological Sciences, Perinatology and Puericulture of Rome University "La Sapienza" during the period October 2004 to October 2005. In this period a questionnaire for self-evaluation was given to all pregnant women between the 28th and 40th week of gestation who underwent a routine ultrasound scan at our department. The questionnaire followed the EPDS (Edinburgh Postnatal Depression Scale) which comprises ten items. On the basis of the reply given, each item receives a certain number of points (Table 2). The score considered as a threshold value of cutoff is 12.5 and indicates the need for deeper examination. Since the EPDS identifies 86-95% of those women considered to be depressed [12], this screening tool enables specialists to contact the mothers to offer their services and give them the opportunity to discuss their emotions more fully. The study maintains that women with a point count over 12 should discuss matters with a professional. To the ten items of the EPDS certain risk factors, specific for the development of PND, were added:

Personal data:

– age
– civil status
– education
– work
– information regarding pregnancies, previous births and their course
– help received from the family.

Table 1. — *Incidence of depressive disturbances during postpartum in Italy.*

Age at delivery	Short-time depression	Long-term depression
Up to 24	26.4%	4.5%
25-29	33.9%	5.3%
30-34	29.7%	4.1%
35-39	36.7%	2.0%
40 and over	17.4%	3.6%
Total	31.2%	4.2%

Table 2. — *Example of 1 item of the EPDS.*

I feel unhappy and sad	Score
Yes, most of time	3
Yes, quite often	2
Sometimes	1
Never	0

One section of the questionnaire was dedicated to the use of methods of prenatal diagnosis and a self-evaluation of the patients regarding the ultrasound examinations carried out.

Our sample excluded patients with a confirmed diagnosis of depression or with evident psychic disturbances and/or under treatment for them. The study covered 222 patients in gestation between the 28th and 40th week who replied to the questionnaire without any difficulty.

Statistical analysis of the data collected was effected by means of the chi square test for calculation of the correlation between risk factors and those patients who were positive to the screening test during pregnancy, namely those women with an EDPS point count during gestation of over 12. Numerous studies have stressed the importance of PND as a precursor of postpartum depression (PPD) [13, 14].

Results

Certain personal, social and obstetric factors of particular interest were taken into account. The 222 patients were distributed percentage-wise as follows:

– Age: 4.7% up to 24 years old; 75.6% between 24 and 37 years old; 20.3% over 37 years old
– Nationality: 79.7% Italians; 20.3% Foreigners
– Occupation: 67.6% employed; 32.4% unemployed
– Social status: 5.4% single; 93.2% married; 1.4% separated
– Study education: 1.4% primary school; 66.2% secondary school; 32.4% college or university degree
– Epidural anaesthesia at delivery: 30.3% yes; 69.7% no
– Antenatal diagnostic methods: 42.9% Bi-test; 4.1% Tri-test; 53.1% amniocentesis; 33.8% none
– Parity: 55.4% first pregnancy; 44.6% second or other pregnancy
– Delivery method: 54.5% vaginal; 45.5% caesarean section
– Previous obstetrical history: 9.1% miscarriage threat; 59.1% miscarriage; 9.1% preterm delivery threat; 13.6% hypertension/eclampsya; 4.5% IUGR; 4.5% preterm delivery.

Sixty-three patients were positive to the screening test, namely those with an EPDS point count of over 12, representing 28.4% of the sample, while 159 (71.6%) were negative. The data are very close to the averages found in other studies in the literature analysed.

From the subsequent analysis of patients with an altered EPDS (total score > 12) we considered the risk factors with the following results:

– Age: 9.5% up to 24 years old; 28.6% between 25 and 28 years old; 14.3% between 29 and 32 years old; 28.6% between 33 and 36 years old; 9.5% between 37 and 40 years old; 9.5% over 40 years old
– Nationality: 28.8% Italian; 26,7% Foreigner
– Occupation: 65% employed; 35% unemployed
– Social status: 9.7% single; 90.3% married
– Study education: 81.6% secondary school; 18.5% college or university degree
– Parity: 57.1% first pregnancy; 42.9% second or other pregnancy

– Delivery method: 33.3% vaginal; 66.7% caesarean section

– Previous obstetrical history: 38.1% miscarriage; 61.9% normal.

The hypothesis would therefore seem to be that there is a continuum between depression suffered pre- and post-partum, and that the depression begins during pregnancy and then becomes more acute or less latent at the time of confinement. In these studies the percentage of women with prenatal depression found among those exposed to the EDPS was between 10 and 20%.

Conclusions

The conclusions of our study confirm that depression begins during pregnancy and then extends into the post-partum phase. In these cases gynaecologists can observe the existence of the problem: meaning that during the daily clinical routine those patients showing risk factors for development of psychological discomfort need to be monitored. The earlier the problem is recognised the greater are the possibilities of therapy and of preventing any consequences that could affect the entire family. The doctor can help the patient if he/she:

1) Assembles a personal case history, a remote pathology and an obstetric pathology which are as accurate as possible; 2) Obtains data on the social/financial condition of the patient and on the support the patient can count on from the family; 3) Proposes that during the pregnancy the patient completes screening tests, such as EPDS questionnaires, which are quick, economical, easily found and rapidly evaluated; 4) Proposes that the patient attends courses of physical and psychological preparation for childbirth, to clear up all doubts and minimise anxiety regarding the pregnancy and the "birth event" itself; 5) Proposes psychological support from a specialist for patients with a positive EPDS point count, thus fostering a multi-facetted approach to the problem; 6) Follows and supports the mother regarding the availability of activities aimed at helping her through this delicate period, such as "confinement at home".

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