Non-Communicable Diseases Watch

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衞生防護中心 Centre for Health Protection

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Postpartum Depression: A Public Health Problem

Key Facts

※ Postpartum depression is a common health issue with global prevalence between 13% and 19%. In Hong Kong, about one in every ten women develops depression after giving birth.

※ Various clinical, psychosocial, obstetric- and infant-related factors increase women's risk of postpartum depression.

※ Postpartum depression can impair women's ability to nurture their infants, and as such potentially impact on infant's well-being, growth and development.

Prevention Tips and Coping Strategies

For the Prospective Mothers and Postpartum Women

※ Prepare adequately before pregnancy by appropriate family and financial planning.

※ Have realistic expectations for parenthood. Learn more about pregnancy, childbirth and childcare to minimise anxiety.

※ Cultivate effective communication with spouse and other family members to improve understanding and support.

※ Ensure enough rest and sleep. Cut down on unimportant responsibilities, e.g. arranging household and childcare help after childbirth.

※ Have a healthy diet. Do not smoke. Avoid beverages containing alcohol or caffeine.

※ Spare yourself some time for leisure and relaxing activities.

※ Get to know other mothers for experience sharing and social support.

※ Seek help for any childcare problems or emotional issues from health professionals if indicated.

For Spouse and Other Family Members of the Postpartum Woman

※ Give the postpartum woman time and space to talk about her feeling.

※ Help with household chores and share childcare responsibility.

※ Encourage the postpartum woman to take time for herself.

※ Learn about postpartum mood disorders. Do not overlook depression symptoms.

※ Assist the postpartum woman in seeking help if indicated.

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Postpartum Depression: A Public Health Problem

Many pregnant women and their families expect the postpartum period to be a happy time, characterised by the joyful arrival of a new baby. However, with the hormonal changes, the role change, challenges in baby care and family problems, the time following childbirth could be a time of increased risk for mood disorders among women.

There are three main categories of postpartum mood disorders: postpartum (baby) blues, postpartum depression and postpartum psychosis, each of which differs in its prevalence, clinical presentation, level of severity and management (Box 1).[1]

Box 1: Types of postpartum mood disorders[1-3]

Postpartum Blues	Postpartum Depression	Postpartum Psychosis
It affects about 40% to 80% of postpartum women.	It affects about 13% to 19% of postpartum women.	It affects about 0.1% to 0.5% of postpartum women.
It is a transient state characterised by mood swings, tearfulness, troubled sleeping and irritability.	Symptoms can be no different from a depressive episode experienced at other times. Postpartum depressed women also have self-blaming thoughts and guilt about their inability to look after their new baby.	Symptoms resemble an acute manic episode or a psychotic depression with three prominent clinical features: hearing non-existing voices; bizarre thoughts of being harmed by others; and ideas of self-harm or infant-harm.
The symptoms are relatively mild and often settle spontaneously within days.	Apart from counselling, treatment with anti-depressants may be required.	This is a psychiatric emergency that requires immediate medical care.

Postpartum blues are transient reactions to the hormonal changes and stress after delivery. They usually occur 3 to 5 days after childbirth and can last for several days. As symptoms are relatively mild and settle spontaneously within days, treatment is generally not required other than understanding, listening and support from others.

Unlike postpartum blues, most cases of postpartum depression do not resolve on their own and interventions may be required. The onset of depression after delivery is insidious and gradual. Symptoms usually appear within six weeks but can also occur anytime within a year after childbirth. Symptoms can be no different from a depressive episode experienced at other times, including persistent low mood; marked diminished interest in usual activities; loss of appetite; fatigue and loss of energy; troubled sleeping or early morning wakening; difficulty in concentration and making decisions; feeling of worthlessness and hopelessness; and recurrent thoughts of death or suicide. Postpartum depressed women would also have self-blaming thoughts and feelings of excessive guilt about their inability to look after their infant.

For postpartum psychosis, this is a rare condition. The clinical onset usually occurs within 14 days after childbirth or even later with psychotic symptoms manifested by delusions, hallucinations, or both. Being regarded as a psychiatric emergency, women with postpartum psychosis require immediate medical care.[1-3]

Epidemiology of Postpartum Depression

Prevalence

Depending on the population sampled, assessment tools or measurements (such as using the Edinburgh Postnatal Depression Scale (EPDS) or the Center for Epidemiologic Studies Depression Scale (CES-D) which are self- or interviewer-rating questionnaires, or Structured Clinical Interview for Diagnostic and Statistical Manual of Mental Disorders (DSM) which is a structured interview to generate an operationalised diagnosis that would fulfill DSM criteria) and the timeframe (during the first 6 months, the first 3 months, or the first 4 weeks after delivery) used for diagnosing postpartum depression, meta-analysis and systematic review of epidemiological studies (mostly from Western societies) estimated the global prevalence of postpartum depression to be between 13% and 19%.[3] In Asian countries, the rates of postpartum depression varied from 3.5% (Malaysia) to 63.3% (Pakistan).[4]

Risk Factors

The exact causes of postpartum depression are unknown. While changes in hormone levels after delivery may play a role in vulnerable women, epidemiological studies have implicated various clinical, psychosocial, obstetric- and infant-related factors in increasing women's risk of postpartum depression. Major risk factors for postpartum depression are shown in Box 2.[3, 5-14] Many of these risk factors, if not all, can be prevented or are amendable to early detection and interventions.

Postpartum depression has significant impact on the mother, child and spouse. It is associated with poor mother-infant bonding[15], negative infant feeding outcomes (such as decreased breastfeeding duration)[16] , receiving fewer preventive services[17], a small but significant effect on children's cognitive (such as language and IQ) and emotional development[18, 19] and disrupted family relationships. By early recognition and interventions together with empathetic support from family, however, most mothers with postpartum depression can recover and resume normal lives.

Box 2: Major risk factors for postpartum depression

Clinical factors

Previous psychiatric conditions—Women with a history of psychiatric conditions such as minor depression, major depression or anxiety were at 70% increased risk of developing postpartum depressive symptoms (EPDS >12) as compared to women without such conditions.[8]

Antepartum emotional problems—Women with antepartum emotional problems such as anxiety or depression were at 39% increased risk of developing postpartum depressive symptoms (EPDS >12) as compared to women without antepartum emotional problems.[8]

Psychosocial factors

Vulnerable personality—Women with an anxiety-prone personality were 2.3 times as likely to develop postpartum depression (in accordance to the DSM criteria) as women without such personality.[9]

Lack of social support—Women who always perceived social isolation during antenatal period were about 3.6 times as likely to develop postpartum depressive symptoms (EPDS ≥13) as women who never perceived social isolation.[10]

Poor marital relationship—Women with a dissatisfactory marital relationship were 6.4 times as likely to develop postpartum depression (in accordance to the DSM criteria) as women with a satisfactory marital relationship.[9]

Dissatisfied in-law relationship—In a prospective study among Chinese women, those having a dissatisfied relationship with mother-in-law were 4.7 times as likely to develop postpartum depression (in accordance to the DSM criteria) as women having a satisfied relationship with mother-in-law.[9]

Domestic violence—Women who experienced partner violence during pregnancy were about 3 times as likely to develop postpartum depressive symptoms as women who did not experience partner violence during pregnancy.[11]

Multiple births— Mothers of multiple births had 43% increased risk of having moderate depressive symptoms (CES-D score 10-14) or severe depressive symptoms (CES-D ≥15) at 9 months after delivery compared to mothers of singletons.[12]

Obstetric-related factors

Perinatal complications—Women who experienced pre-eclampsia, hospitalisation during pregnancy, suspicion of fetal distress, emergency caesarean section, hospital admission of the baby had 158%, 125%, 56%, 53% and 45% increased risk of postpartum depressive symptoms (EPDS >12) compared to women who had no perinatal complications respectively. The risk of postpartum depressive symptoms also increased with the number of perinatal complications that women experienced.[13]

Infant-related factors

Infantile colic (i.e. episodes of crying for more than three hours a day for more than three days a week for three weeks in an otherwise healthy infant)—At 6 months after delivery, mothers reporting infants with colic at 2 months of age were 3.7 times as likely to have postpartum depressive symptoms (EPDS >12) as mothers of infants without colic.[14]

Local Situation

Prevalence

The rate of postpartum depression among women in Hong Kong is comparable with the global rate. Overall, about one in every ten local women developed depression after giving birth — 10.3% at one month postpartum and 11.2% at three months postpartum.[20-22] However, a more recent prospective cohort study with 805 Chinese women who attended the 9 Maternal and Child Health Centres (MCHCs) of the Department of Health (DH) for routine antenatal care at their third trimester during the period 1 August 2009 to 31 August 2010 and were interviewed at about 2 months after childbirth observed a 2-month prevalence of postpartum depression of 15.7%.[9]

Postpartum Screening Programme

In Hong Kong, universal postpartum depression screening is one of the components of the Comprehensive Child Development Service (CCDS) in MCHCs, and is collaborated with the Hospital Authority (HA) and Social Welfare Department. Trained MCHC nurses assess mothers' mood by clinical interview and use of EPDS. Eligible mothers are screened during child health or postnatal visits to MCHCs and some of them would be screened at the postnatal clinic in hospitals under HA. MCHC nurses provide initial assessment and counselling to mothers who are screened positive. Mothers in need of social support are referred to social workers for assessment and support. Those with suspected depression or other psychiatric symptoms are referred to HA psychiatric services, including detailed assessment and counselling by psychiatric nurse visiting MCHCs.

Prevention of Postpartum Depression

Mental wellbeing is crucial for a mother after delivery to appreciate the joys of motherhood, enjoy mother-infant relationships, cope with childcare-related stress, function optimally and prepare for the infant's growth and development. To reduce the risk and impact of postpartum depression, here are some prevention tips and coping strategies for the prospective mothers and postpartum women —

* Prepare adequately before pregnancy by appropriate family and financial planning.
* Have realistic expectations for parenthood that can help adjustment to life after delivery. Learn more about pregnancy, childbirth and childcare to minimise anxiety through various means, e.g. participating in antepartum talks and workshops.
* Cultivate effective communication with spouse and other family members to improve understanding and support.
* Ensure enough rest and sleep. Cut down on unimportant responsibilities, e.g. arranging household and childcare help after childbirth.
* Have a healthy diet. Do not smoke. Avoid beverages containing alcohol or caffeine.
* Spare yourself some time for leisure and relaxing activities, e.g. going for a walk or visiting friends.
* Get to know other mothers/couples for experience sharing and social support. Join childcare and parenting workshops in MCHCs.
* Seek help from health professionals for any childcare problems or emotional issues if indicated.

Spouse and family members can also help the postpartum woman. Here are some suggestions —

* Give her time and space to talk about feeling.
* Help with household chores and share childcare responsibility.
* Encourage postpartum woman to take time for herself, e.g. taking a nap, going for a walk or spending time with friends.
* Learn about postpartum mood disorders. Do not overlook depression symptoms.
* Assist postpartum woman in seeking help or accompany her to see family doctor or professional counsellor if indicated.

To know more about family planning, maternal health (antepartum and postpartum care) or guidance on childcare and parenting, please visit MCHCs of DH, call Family Health Service (FHS) 24-hour Information Hotline at 2112 9900 or visit FHS website at http://www.fhs.gov.hk/.

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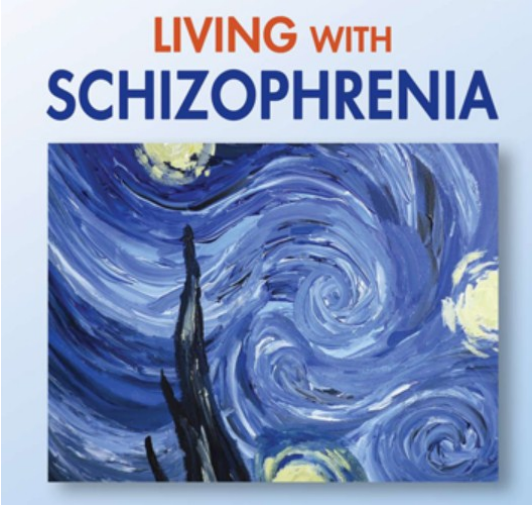
World Mental Health Day

10 October 2014

World Mental Health Day was initiated by World Federation for Mental Health (WFMH) in 1992 to highlight the importance of mental health. Each year, a theme would be chosen to highlight a global public health concern. For 2014, the theme is '**Living with Schizophrenia**'.



Schizophrenia is a serious mental disorder that often develops in adolescence or early adulthood. The disease affects approximately 24 million people worldwide. People with schizophrenia experience a range of symptoms that may make it difficult for them to judge reality. The impact that schizophrenia has on people's lives varies considerably. Some only ever have one 'psychotic episode' where they are very unwell, and then manage to maintain their wellness. Others may recover for sometime, and then relapse and have another psychotic episode. For some, the symptoms of schizophrenia remain constant for the rest of their life. While there is no cure for schizophrenia at the moment, treatments are available which are effective for most people.

To know more about schizophrenia, World Mental Health Day and related activities, please visit http://wfmh.com/world-mental-health-day/.

Non-Communicable Diseases (NCD) WATCH *is dedicated to promote public's awareness of and disseminate health information about non-communicable diseases and related issues, and the importance of their prevention and control. It is also an indication of our commitments in responsive risk communication and to address the growing non-communicable disease threats to the health of our community. The Editorial Board welcomes your views and comments. Please send all comments and/or questions to so_dp3@dh.gov.hk.*

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