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Perinatal Depression: Current Management Issues

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Clinical Importance of Depression

- Depression is one the most common health problems women experience
- It is estimated that 20-25% of women will experience depression during their lifetime
- Further, for 30-50% of women who do experience depression, it is estimated to become a chronic recurring condition

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- Although depression affects individuals throughout the lifespan, women are at <u>increased risk during their reproductive years</u>

- In North America, outside of obstetrics, depression is the leading cause of hospitalizations among women ages 15 to 44

Antenatal Depression

- Prevalence across pregnancy: 12.7% (18.4% with minor depression) *(Gavin et al, 2005)*

Postpartum Depression (PPD)

- Prevalence in the first 12 weeks postpartum: 13% *(O'Hara & Swain, 1996)*

→ For women with a <u>history of depression</u>, 35% PPD rate

→ For women with <u>depression during pregnancy</u>, 50% PPD rate

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Persistence of PPD

- For the majority of mothers, PPD starts within the first 12 weeks postpartum

- National Canadian data suggest 8% of mothers will continue to experience PPD past the first 5 months postpartum and into the following year *(Dennis, et al 2012)*

→ this rate is more than 4 times the 1.4% point prevalence for depression among women found in the Canadian Community Health Survey

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Most frequent form of maternal morbidity following childbirth

Unfortunately, PPD occurs at a time when the infant is:

- Maximally dependent on parental care
- Highly sensitive to the quality of the interaction

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- Given the persistence of PPD and its association with recurrent depressive episodes *(Copper et al 2003; Nylen et al 2010)*, concern for child development is warranted as maternal depression can:

1. Be incompatible with good parenting cognitions and behaviours
2. Cause significant distress for children due to a stressful home environment *(Goodman &Gotlib 1999)*

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Health Promotion Consequences

- Research suggests maternal health promotion behaviours are diminished as mothers with PPD are <u>less likely</u> than non-depressed mothers to:
  - Breastfeed
  - Attend well-child visits
  - Complete immunizations
  - Use home safety devices
  - Put infants to sleep on their back
  - Engage in enriching activities (reading, singing, outdoor activities)

(Zajicek-Farber 2009; Cadzow et all 1999)

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Child Developmental Consequences

- Mothers with PPD also have children with poorer developmental trajectories

- Risk transmission through altered maternal-child interaction *(Rishel, 2012)*

Does treating maternal PPD improve child developmental outcomes?

- A systematic review that examined associations between improvements in parents' depression and their children's psychopathology confirmed the positive effects of treatment *(Gunlicks & Weissman 2008)*

⟶ Need to treat to complete remission

Management of Perinatal Depression

Case Identification

- The first step in the management of PPD is case identification

- Research consistently demonstrates that informal surveillance is imprecise with less than 50% of mothers with perinatal depression identified despite various interactions with health professionals *(Yawn et al 2012; Goodman & Tyer-Viola, 2010)*

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Antenatal Screening

- You can screen antenatally but only if it is to identify women with current depressive symptoms needing intervention → not to identify asymptomatic women at risk of developing PPD

Postnatal Screening

- Various generic depression screening tools have been used in perinatal population
- However, the majority of clinicians and researchers use a specialized PPD screening tool
- The most widely used is the Edinburgh Postnatal Depression Scale (EPDS)

Edinburgh Postnatal Depression Scale (EPDS)

- 10-item self-report instrument
- Scores range from 0 to 30
- Cut-off 12/13 (> 12) – probable PPD
- Cut-off 9/10 (> 9) – possible PPD
- Widely available and free

EPDS

- Validated for antenatal use
- Translated and psychometrically tested in many non-English populations
- Surveys of large samples of perinatal women have found acceptability to be high (80-90%)

- Critical factor
  - Provides a common language
  - Enables comparability of clinical and research results

Health Professionals

- Researchers have examined PPD screening in diverse settings with differing professionals including:
  - Public health nurses
  - Obstetricians
  - Midwives
  - Family physicians
  - Paediatricians
  - Nurse practitioners

Does perinatal depression screening increase the number of mothers who recover?

- Research clearly suggests that screening alone is insufficient to ensure the provision of appropriate treatment and thus ultimately improving clinical outcomes

- The U.S. Preventive Services Task Force recommends screening adults for depression in clinical practices that have systems in place to assure:

1. Accurate diagnosis

2. Effective treatment

3. Follow-up

Effective Treatment Tools

Pharmacological

Psychological

- Interpersonal psychotherapy (IPT)
- Cognitive behavioural therapy (CBT)

Psychosocial

- Peer support /support groups
- Non-directive counselling

Alternative

- Relaxation/Massage
- Exercise
- Yoga
- Bright light therapy

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Maternal Treatment Preferences

- While pharmacological interventions are effective in the treatment of PPD, many mothers prefer “talking therapies” → especially if they are breastfeeding (*Dennis & Chung-Lee, 2006*)

Interpersonal Psychotherapy (IPT)

- Interpersonal psychotherapy (IPT) is a common and effective ‘talking therapy’ for depression

- At least 8 studies have evaluated the effect of IPT on depression during the pregnancy and postnatally

- Unfortunately, IPT is not widely available, especially in rural and remote areas

- There are also long wait-times to receive IPT from a trained psychiatrist or psychologist

- PPD treatment has unique barriers (e.g. childcare issues) and high attrition rates in group or clinic-based PPD treatment programs

→ **suggest the need for novel treatment modalities**

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Telepsychiatry

- To improve access to care, telepsychiatry has been introduced and includes the provision of psychiatric services via telephone
- Telepsychiatry can play an important adjunct role within an integrated health care system
- It is predicted to become an increasingly acceptable alternative to traditional face-to-face services
- The provision of IPT by trained nurses can also increase the clinical utility and feasibility of this treatment option

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Interpersonal Psychotherapy Trial

An RCT to Evaluate the Effectiveness of Telephone-Based Interpersonal Psychotherapy for the Treatment of Postpartum Depression

Funding: CIHR

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- While effective treatment *tools* exists for PPD, less than 30% of mothers with depression in the first year postpartum receive adequate treatment

- Common barriers to treatment include:
  1. Maternal preferences and perceived barriers
  2. Lack of clear referral pathways
  3. Lack of follow-up

- Systematic treatment ***approaches*** are required to address the gap between the existence and uptake of effective PPD treatment tools

Collaborative Care

- "Collaborative care" is an *approach* to treatment that is highly effective for the management of general depression

- In a collaborative care model, case identification occurs at the primary care level

- A depression care manager directs individuals to appropriate treatment and monitors progress – all in collaboration with a mental health specialist

Treatment Follow-Up

- Part of the success of this approach is that it actively promotes treatment initiation and adherence while addressing patient preferences and perceived barriers

- Also ensures appropriate follow-up and treatment to remission

Treatment: Evaluating New Approaches

Evaluating Collaborative Care for **P**ostpartum **D**epression in Paediatric Primary Care **S**ettings

Funded: CIHR

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Design Overview

- A RCT will be conducted to evaluate the effect of a collaborative care intervention for depression on diverse maternal and infant outcomes among mothers between 0 to 6 months postpartum with depressive symptomatology identified during well-child visits in eight primary care practices across Toronto

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Is there any evidence to suggest we can effectively PREVENT postpartum depression?

Cochrane Systematic Review

Psychosocial and Psychological Interventions for the Prevention of Postpartum Depression:

An Update

Dennis, C-L., Dowswell, T. (2013). Psychosocial and psychological interventions for preventing postpartum depression. The Cochrane Database of Systematic Reviews, Issue 2.

Summary

- Overall psychosocial and psychological interventions may decreased the risk of developing PPD by approximately 22%

- There is beginning evidence to suggest the importance of:

1. Additional professional support initiated postnatally
2. Telephone-based peer support initiated postnatally
3. Interpersonal psychotherapy (IPT)

- Interventions are more likely to be beneficial if they are:
  - Initiated postnatally
  - Individually-based
  - Include multiple contacts
  - Target ‘at risk’ women

- Postnatal interventions that were successful →administered Edinburgh Postnatal Depression Scale (EPDS) early in the postpartum period to identify depressive symptomatology

- Secondary preventive interventions

Canadian PPD Prevention Trial

Postpartum Depression Peer Support Trial

(Dennis, C-L., Hodnett, E., Kenton, L., Weston, J., Zupancic, J., Stewart, D., & Kiss, A. (2009). The effect of peer support on prevention of postnatal depression among high-risk women: a multi-site randomized controlled trial. *British Medical Journal*, 338:a3064).

Funding: CIHR

Summary

- Telephone-based peer support may be effective in preventing PPD among high-risk mothers

- Mothers who received peer support were at half the risk to develop PPD

Postpartum Depression:

A Family Affair

Paternal PPD Prevalence

- A recent meta-analysis suggests that approximately 10.4% of fathers will experience depression in the first year postpartum
- This rate is significantly higher than the 12-month prevalence of 4.8% found in US national data for general depression in men.

(Paulson et al. 2010)

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- Some evidence that PPD in fathers begins later, often following the onset in mothers and with the rate increasing over the first year postpartum

Paternal PPD Consequences

- Evidence is beginning to accumulate that fathers can also have a serious negative influence on child outcomes

- While fathers' roles vary widely between and within different social and cultural groups, in most countries fathers have an active role in childcare

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Dual Parental Depression

- It has been hypothesized that dual parental PPD has an additive effect on infants, placing them at even higher risk for adverse outcomes than those who only have one depressed parent

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Mechanisms: Single vs. Dual Parental Depression

Impact of **M**aternal and **P**aternal Postpartum Depression: **A**ssessing **C**oncurrent Depression in **T**he Family

(The IMPACT Study)

Funded: CIHR

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Design Overview

- A longitudinal study where 5000 mothers + fathers across Canada will complete questionnaires at 3, 6, 9, 12, 18, and 24 months postpartum

- Objective: to examine the impact of parental depression in the first 2 years of a child's life

→ focus on understanding the mechanisms by which single (maternal PPD only or paternal PPD only) versus dual (maternal and paternal PPD) parental depression affect infant outcomes

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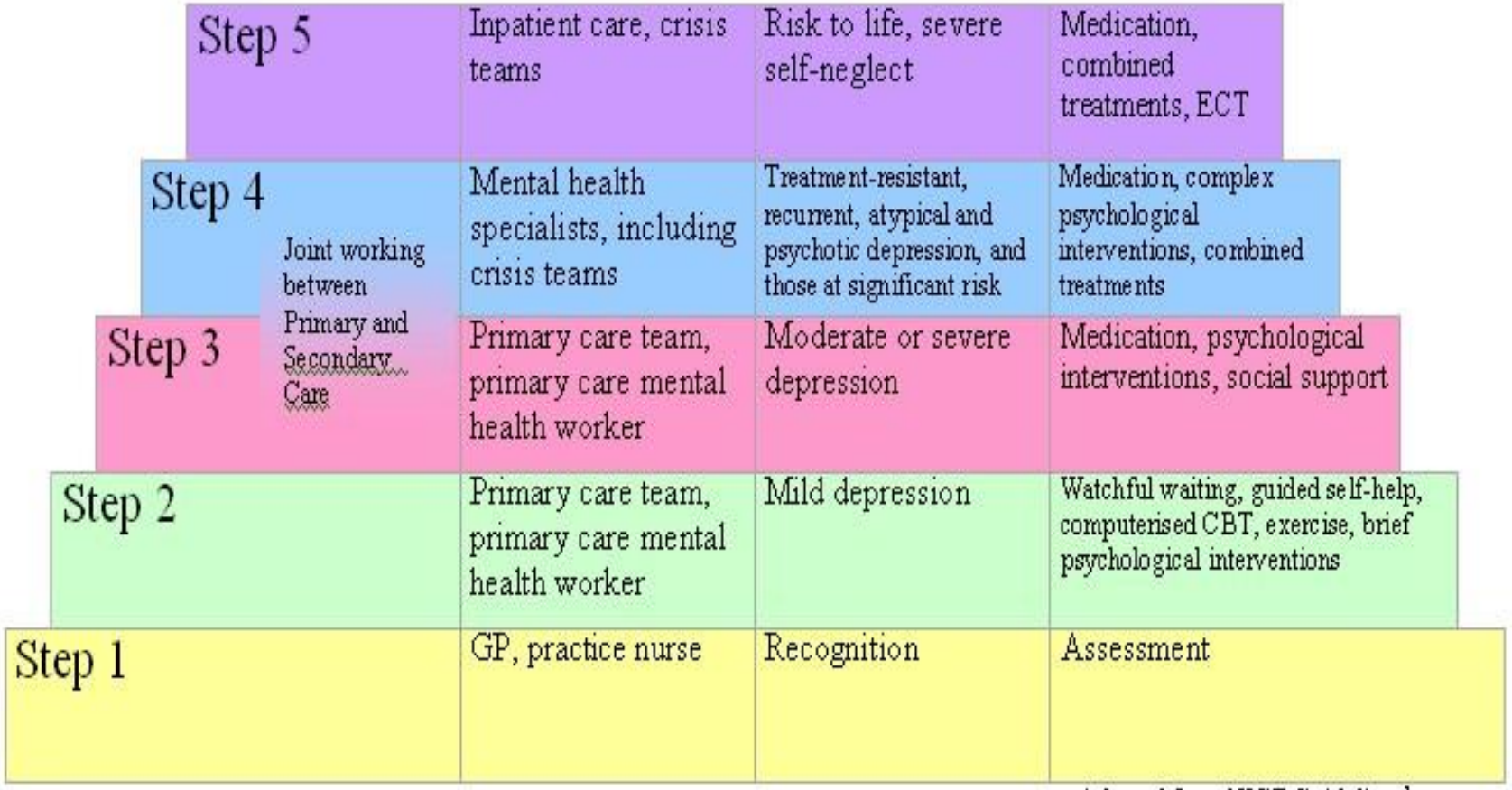
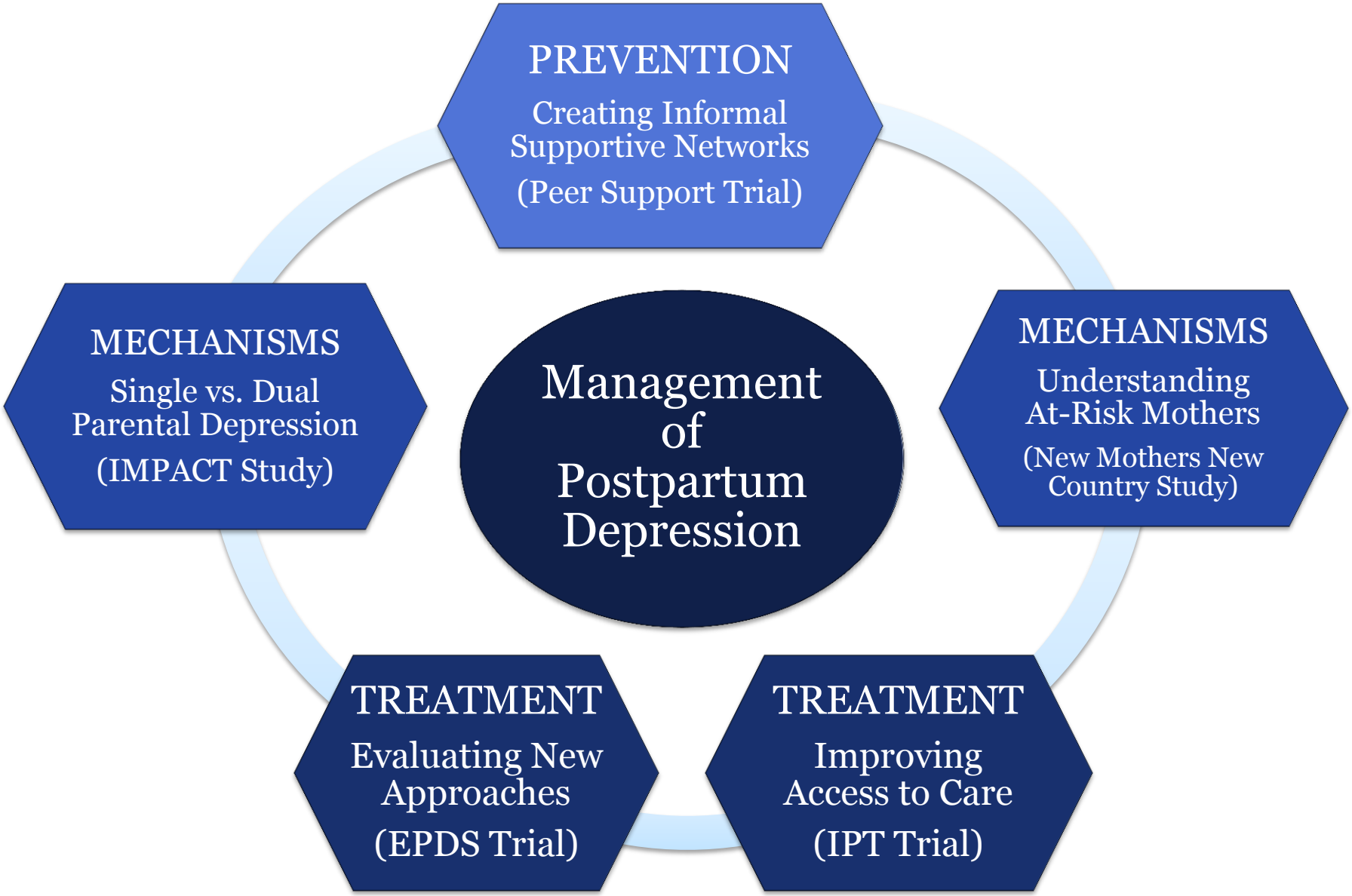
NICE Guideline for Depression

- Recommends a stepped care framework that aims to match the needs of adults with depression to the most appropriate services



Adapted from NICE Guidelines[1]

Research Initiatives: $6 million Investment



Questions

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