Postnatal depression and screening: too broad a sweep?

FOR almost 40 years, GPs have repeatedly been told[1,2] that they fail to detect up to 50% of depression in primary care and that, if detected, they fail to treat it properly. Over the same period we have seen the introduction of vocational training which includes psychiatry, the Defeat Depression Campaign, countless research studies of depression in general practice, numerous guidelines and protocols on the detection and management of depression — all apparently to little avail. The widespread use of the Edinburgh Postnatal Depression Scale (EPDS) to screen for postnatal depression (PND) is based on the assumption that, without screening, significant numbers of women with postnatal depression would go undetected.[3]

This view of a substantial morbidity due to undiagnosed depression in primary care perhaps needs to be challenged. Some studies would suggest[4] that clinically significant depression — moderate to severe depressive illness — is detected, which raises the issue of what might be the matter with the rest. The numbers of the general population identified by screening schedules, such as the General Health Questionnaire (GHQ) or the Clinical Interview Schedule (CIS)[5], are greater than the number diagnosed at clinical assessment as suffering from a depressive illness. The remainder will undoubtedly include those in transient crises, the unhappy and those suffering with 'sub-syndromal' depression.[6] Also open to challenge is the appropriateness of the medical model of diagnosis and treatment in such cases.[7]

Neither the use of screening schedules for depression nor management guidelines appear to improve clinical outcome, either in depression in general[8,9] or in PND.[10]

It is amazing that a condition which does not exist in the Internal Classification of Disease 10th Version (ICD 10) should have such a popular profile and result in so many articles in scientific journals. Countless careers rest upon research into PND and the use of the EPDS, yet there is no good evidence that mild to moderate depression is any commoner after childbirth than in the non-postpartum population.[11] Nor is there any evidence that its clinical features or treatment are different. As at other times, counselling, cognitive behavioural psychotherapy and antidepressants are equally effective in the short term, but most improve even without treatment in the longer term.[12,13,14]

The importance of perinatal mental illness, not just PND, is centred upon two other issues. Firstly, the context distinguishes depression at this time from depression at other times. There is an expectation of happiness and fulfillment. Depression following childbirth is particularly distressing, interferes with the adjustment to motherhood, leaves lifelong memories of unhappiness and guilt and can profoundly affect relationships, particularly marriages and other children. Most importantly, there is overwhelming evidence to show that PND, particularly if untreated and chronic, combined with social adversity and marital conflict, has measurable adverse effects both in the short and long term on infants, particularly boys. For these reasons alone, the prompt diagnosis and effective treatment of PND is essential.

The second distinctive issue is that, despite the ICD 10's view, it has long been established that there is an increased risk of women becoming seriously mentally ill following childbirth and a particularly high risk of those who have suffered in the past from serious mental illness having a recurrence of that condition. Puerperal psychosis, which occurs in approximately two out of every 1,000 deliveries, is a rare event, but nonetheless represents a dramatic increase in risk of suffering from a psychosis and being admitted to a psychiatric hospital following childbirth.[15]

Perhaps more important is the increased risk of the commoner severe depressive illness estimated to occur in 3–5% of all delivered women.[16] These serious postpartum mental illnesses are linked with a substantial mortality and morbidity.[17] The EPDS is unlikely to assist in the detection of either of these conditions, partly because their presentation is before the time when the EPDS is most commonly used — between six and eight weeks postpartum — and partly because a symptom profile of these conditions is not covered by the EPDS.

Depression following childbirth, as at other times, lies on a spectrum of severity and sub-types with different symptoms and different treatments. The Confidential Enquiries into Maternal Deaths (CEMD)[17] found that the term postnatal depression was used as a generic term for all types and severities of mental illness following childbirth. It is of concern that the term PND should be used in this way and of equal concern that the use of arbitrary cut-offs on the EPDS should be used to diagnose PND. It has perhaps led to a false idea of homogeneity of the conditions and a 'one-size-fits-all' view of their treatment. Differential diagnosis of perinatal mental illness in general, and of depressive illness in particular, is as important in the postpartum period as at other times.

The paper on the acceptability of the routine use of the EPDS, published in this volume,[18] adds to the increasing concerns about the routine use of the EPDS in screening for postnatal depression. The EPDS, designed initially as a research screening schedule,[3] was always intended to be followed by a clinical diagnosis or the use of a gold standard psychiatric assessment schedule. All too frequently, it is now used both in clinical practice and research as a diagnostic instrument. While its sensitivity and specificity is generally held to be very good, the positive predictive value varies greatly between studies and with the cut-off score used. The specificity falls with lower scores.[10] Little attention is ever drawn to the large number of false positives, that is to say, those women who were screened with the EPDS as achieving a high score, but who do not suffer from a depressive illness. This ranges from between 30–70% false positives.[10,19] While this may not be important in research, misattributing unhappiness in large numbers of women to PND, with its potential for unnecessary and inappropriate treatment, does matter in clinical practice. Over-diagnosis also carries the potential for overwhelming services and perhaps distracting health visitors and secondary psychiatric services from other tasks.

The EPDS should only be used by trained personnel,[10,20] yet often it is not. Sometimes it is posted, left in clinics or given face to face — the results will differ. It may not be as acceptable to women as previously thought.[18] The EPDS was designed to pick up minor depression in primary care that might benefit from extra time with a health visitor, the 'listening visit'.[20] Frequently it is seen as an indication for treatment by another professional. Although psychological treatments and antidepressants are equally effective,[12,14] the lack of counselling resources and skills results in many women with PND receiving antidepressants rather than the alternative — to the delight of the pharmaceutical industry no doubt. PND may be making a substantial contribution to the exponential rise in the prescribing of SSRIs since 1991, now thought to be in excess of the incidence of depressive illness. Only 3–5% of women delivered will meet the criteria for ICD 10 moderate to severe depressive illness,[16] normally considered to be the threshold for prescribing antidepressants.[21]

The EPDS is also widely used in the antenatal period to screen for those women thought to be at risk of developing PND. Its use in this way is not supported by the Scottish Intercollegiate Guidelines Network (SIGN) on the Management of Postnatal Depression and Puerperal Psychosis,[22] the National Screening Committee,[23] or the forthcoming NICE Antenatal Care Guidelines, and indeed all make mention of the lack of evidence that there are any useful predictors in the general population for PND. This is in contrast to the substantial evidence that a previous psychiatric history of severe mental illness, postpartum or otherwise, predicts a 1 in 2 chance of recurrence following delivery.[15] The National Screening Committee's document on screening for PND is unconvinced that screening improves the rate of diagnosis or that it improves clinical outcome. It also comments that it is unethical to screen unless the skills and resources are in place to treat those who are detected. Similar conclusions had been drawn in other settings.[8,9]

Childbirth is a time of psychological and social change. Nothing will ever be the same again, particularly for first-time mothers. Personalities, coping styles and marriages are tested to their limit. Turbulent emotions and anxiety are commonplace, dependent on sleep, infant temperament, behaviour and health. Diagnosing morbid conditions, particularly depressive illness, is difficult in this context and, in the words of some of Shakespeare's informants,[18] cannot be reduced to 'ringing numbers on a questionnaire'. The EPDS, given at a single point in time, is likely to sweep up not only those who are ill, but those who are temporarily ill, permanently unhappy, or even those who are simply having a bad day.

It remains to be shown how many ill women have been detected by this method who would not have been detected by their midwife, health visitor or GP's clinical skills and experience. Indeed, there have been some suggestions that a clinical diagnosis may be as good, if not better.[10] It remains to be seen how many women were offended and undermined by their valid distress being attributed to PND and how many of their problems, which might have responded to practical assistance, lie unresolved. It also remains to be shown how many women receive antidepressants unnecessarily.

Pregnancy and the postpartum period is unparalleled in the human life span for its level of health scrutiny. Women have high rates of contact with midwives, health visitors and GPs. Their misery will be noticed, as will problematic adjustments to motherhood, and all may be called PND. The CEMD[17] recommends that the term postnatal depression should only be used to describe a non-psychotic depressive illness of mild to moderate severity with an onset within three months of childbirth. Restricting the use of PND in this way might improve the detection and treatment of those who are ill and better understand, validate and assist the distress of those who are not.

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