



Recognition and management of perinatal depression in general practice



A survey of GPs and postnatal women

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OBJECTIVE

To identify ways to improve detection and access to treatment.

METHODS

A survey of general practitioners and postnatal women across Australia addressing knowledge of, and attitudes to, postnatal depression using case vignettes.

RESULTS

General practitioners were significantly more likely to recognise depression than postnatal women, who were likely to seek help for more general or baby related issues. Both GPs and women favoured help from partners and counselling, but GPs significantly favoured antidepressants and women, natural therapies.

DISCUSSION

Women have a low likelihood of presenting for depression, suggesting a role for screening by GPs. Women preferred psychological and social management than drugs for depression perinatally.

Many infant health centres (and some obstetric hospitals) in Australia screen for symptoms of antenatal or postnatal (perinatal) depression. Up to 50% of depression cases will be missed without screening, whether in general practice or infant health centres.^{1,2} General practitioners in Australia see up to 90% of women postpartum,³ affording many opportunities to screen for maternal wellbeing. The Edinburgh Postnatal Depression Scale (EPDS),⁴ is simple to use and effective with training in administering and scoring, giving women appropriate feedback, and understanding its limitations (eg. anxiety).⁵

Women are often reluctant to seek treatment for perinatal depression: 75% of American women believe their symptoms are normal,⁶ and British women are reluctant to accept treatment for it. Medication is particularly regarded adversely.⁷

The *beyondblue* National Postnatal Depression Program was established in 2001 across five Australian states with the aim of evaluating screening for perinatal depression, facilitate the linking of all services involved in the care of perinatal women, and increase community and health professional awareness.

Before starting this program, we sought to evaluate knowledge and awareness of perinatal depression among health professionals and postnatal women, in particular, the extent to which it is recognised and attitudes to its treatment.

Methods

Ethics approval was received from 34 maternity hospitals/area health services. At the commencement of the project, meetings were held with key stakeholders, including The Royal Australian College of General Practitioners, representatives of divisions of general practice, and primary mental health care coordinators.

Population and sample

General practitioners

The name of every division of general practice in Australia was put into alphabetical order, and every third one was contacted by telephone and asked to recruit GPs for the survey. If agreeable, the divisions were provided with pre-packed questionnaires to select and post questionnaires to 25 GPs in their area at their discretion. Reply paid envelopes were provided. Six or more divisions in each of the six states

were approached, of which some in each declined participation (citing lack of interest, lack of appropriate inducement for their GPs, or concern over burdening their GPs excessively).

Women 6–12 weeks postpartum

Women were recruited through local maternal and child health services by asking nurses to recruit the first 10 women seen at the postnatal 6–12 week check to complete three questionnaires. The nurses returned these in prepaid envelopes.

Questionnaires

We developed a depression vignette for both the GPs and the women based on past work (Table 1).^{8,9} Awareness of depression was based on the same work,^{8,9} respondents scoring a high positive awareness if they decided Mary (in the vignette) was depressed, needed help and chose appropriate treatments. Low scores conversely suggest respondents were more likely to miss the diagnosis or need for help. We added positive and negative awareness scores (with maxima of +10 and -10) for each respondent.

General practitioners were asked about their own professional experiences in this area, together with indicators of their experiences. They were also asked about their knowledge of the area with 10 multi-choice questions previously developed.¹⁰

Women were surveyed about their use of health services, with questions about their demographics; problems during pregnancy; their estimates of the adequacy of support needed; any additional help sought; feelings of ante- or post-natal depression and anxiety; and any treatment sought for depression. They were also administered the EPDS as a screening tool for depression. This is a widely used 10 item questionnaire with good reliability and validity, with cut-off points of 12/13 shown to have 68–100% sensitivity and 78–96% specificity for detection of distressed/depressed cases in community samples,^{4,11–13} and validated for Australian populations.¹¹

Analysis

We analysed GPs' and women's scores

Table 1. Vignette used in the survey of GPs and postnatal women

30 year old woman, 29 weeks pregnant with her first child

- Sad, miserable, unable to sleep, lost interest in work and hobbies
- Very concerned about how she is going to cope with new baby and whether she will be a good mother. Her husband described her as 'not her normal self'

Then 6 weeks postpartum

- Crying most days and unable to sleep
- Anxious about baby, being a mother and had wished she were dead

Recommend/usefulness of help (rated 0–5 least to most useful)

- Physical activity, yoga
 - Counselling (couple, individual, telephone)
 - Abstaining from alcohol, special diet
 - Talking to family/friends, partner
 - Self help group/reading in home
 - GP, psychologist/psychiatrist/obstetrician
 - MCHN/midwife
 - Naturopath
 - Admission/ECT
- Usefulness of physical treatments (rated 0–5 least to most useful)**
- Vitamins, minerals, St John's wort
 - Antidepressants
 - Sedatives
 - Analgesic, antibiotics, antipsychotics ('inappropriate')

Table 2. Practice pattern and attitudes of GPs to perinatal depression

Treatment used n=184 (%)		Perceived barriers to all treatments n=290 (%)	
Counselling	9 (5)	None	35 (18)
Medication	9 (5)	Unavailable resources	89 (47)
Cognitive behaviour therapy (CBT)	10 (5)	Family/language or beliefs	44 (23)
Referral to mental health specialist	9 (5)	Reluctance of patient	34 (19)
Counselling and medication	98 (53)	Financial (patient)	22 (12)
All	49 (27)	Denial/nonacceptance of patient	22 (12)
		Community attitudes	4 (6)
Referrals made to n=204 (%)		Negative impact of treating perinatal depression n=243 (%)	
Mother-baby unit	141 (68)	None	40 (20)
Counsellor	142 (69)	Time	164 (82)
Psychiatrist	175 (85)	Economic	61 (31)
Midwife	87 (42)	Emotional involvement	6 (3)
Telephone/crisis line	26 (12)	NA	2 (1)
Naturopath	6 (3)		

NB: Selection of more than one response possible, therefore total percent may equal more than 100%

with Analysis of Variance (ANOVA). Mean scores were derived for each sub-question on interventions, with the individual scores forming a vector of responses. Comparisons were performed using ANOVA, with a global null hypothesis, and specific linear contrasts tested, as well as discriminant function analysis to test if specific sub-questions resulted in differences.

Results

Questionnaires were posted to 1075 GPs from 43 divisions; 246 GPs returned them, a response rate ranging from 16–26% by state. Years of experience as a GP did not differ significantly between states, a mean range of 15.9 years (Tasmania) to 21.5 (Queensland), slightly younger and less experienced than the average Australian GP in 2002 (aged 47.3 years).¹⁴ Their experience with perinatal care was high: 95% had seen such patients, over

half saw 10–19 perinatal women in the past 6 months (Table 2). Their mean knowledge score out of 100 was 66, range between states (Qld not included) 61–70, (SD: 15–20).

Postnatal women

The nurses approached 908 women; 525 returned questionnaires (response rate 57%) (Table 3); 420 women completed the EPDS and the survey of services used (response rate 46%) (Table 4); although there were missing data for 20% in the section on mood and treatment.

The mean EPDS score was 4.5 (SD: 3.6) with a range of 0–20; 24 women had EPDS scores ≥ 13 , and were significantly more likely to rate themselves as depressed or anxious (Table 4).

Some form of help was sought by 191/321 (59%) of women, primarily from family (50%), partner (29%), GP (29.2%), and maternal and child care nurse (28%); mainly for crying of

their babies (40%), general advice (31%), not coping (30%), and sleep problems for themselves (19%) or their babies (17%). Help seeking behaviour was not significantly related to EPDS score ($p=0.068$). Different treatments for depression/anxiety were used (Table 5).

Vignettes

To the question: ‘What’s wrong with Mary?’, 95% of GPs selected at least one depression diagnosis (postnatal more likely than antenatal depression) compared with 32% of women ($p<0.0001$). General practitioners had a significantly higher positive awareness (7.1, SD: 2.7) and corresponding low negative awareness (–0.2, SD: 2.3) compared with the postnatal women, 4.0 (SD: 3.5) and 1.1 (SD: 1.7) respectively ($p<0.0001$). General practitioners’ level of awareness was not influenced by knowledge score, nor years of experience, but years of experience did (positively) influence treatment choices for postnatal depression (Table 6).

Discussion

There are several limitations to the study, with the low response rates among women and GPs and an unknown validity of the survey responses to actual behaviour. If the GPs who responded were biased toward those with special interest and expertise in perinatal mood disorders, they would have had a higher detection rate than their peers (although they are perhaps less likely to differ in attitudes to treatment given the strong pharmaceutical influences on depression treatment in the literature and sponsored education programs).

A low number of women had high EPDS scores because we were using the higher cut-off score rather than more than nine recommended in community samples, to minimise false-positives. Our findings are consistent with

Table 3. Maternal characteristics

	Postnatal women n=525, %	National average of women giving birth 200217 n=253 388, %
Born in Australia	82	78
Married	72	NA
Age 20–29 years	30	43
Age 30–39 years	42	48
First child	64	41
Delivery in private hospital	35	31

Table 4. Relationship of EPDS score to self rating depression and help seeking

	EPDS <13	EPDS ≥ 13 (n=24) (%)
Self rated depression/anxiety	58 (24, n=246)	18* (75)
Sought help	172 (58, n=297)	19 (79)

* $p<0.0001$

Table 5. Help received for depression and anxiety among 84 women who rated themselves depressed

		n (%)				
No help	Help from GP	Psychologist/counsellor	Psychiatrist	Admission	Antidepressants	Herbs/natural remedies
49 (58)	11 (17)	9 (14)	4 (6)	4 (6)	9 (14)	7 (10)

Table 6. Beliefs of usefulness of interventions: GPs and postnatal women

	GPs (n=245)		Postnatal women (n=420)	
	Antenatal n (%)	Postnatal n (%)	Antenatal n (%)	Postnatal n (%)
Antidepressants	189 (77)	237 (97)	91* (22)	228* (54)
Antipsychotics	4 (1)	34 (14)	5 (1)	10* (2)
Nil	0 (0)	0 (0)	13* (3)	16* (4)
Special diet	28 (11)	21 (9)	170* (40)	190* (45)
Vitamins, minerals	107 (44)	58 (24)	361* (86)	329* (78)
Counselling	236 (95)	210 (86)	333 (80)	391 (93)
Naturopath	47 (19)	29 (14)	228* (55)	208* (49)
Assistance from partner	238 (97)	199 (82)	402 (96)	385 (93)

* $p < 0.0001$

previous work; women had a low recognition of depressive symptoms.⁷ This may go some way to explaining why they often do not go for specific help, or if they do (and those with higher EPDS scores are more likely to), they do so for general issues or infant related disorders rather than changes in their own mood. Even among those women who thought they were depressed or anxious, only 17% had seen a GP. Their low recognition and lack of help seeking behaviour may reflect differences in knowledge, or about depression as an 'illness', but may reflect differences in expectations of mood disturbances around childbirth.

There was agreement between both women and GPs in both scenarios that help, such as assistance from partners and counselling, would be beneficial. Yet women strongly preferred natural remedies (eg. 'a special diet', naturopathy, vitamins and minerals; similar to findings from other researchers^{7,15-17}) over GPs' preferences for antidepressant medication. These differences in preference may add to reluctance to seek help.

Most women with depression who saw a GP were prescribed antidepressants, suggesting that they were either prepared to accept this treatment, or this was all GPs offered. As most GPs felt their patients required a significant time investment – if they didn't have the time to provide counselling – medication may have been the most realistic option. Yet a more psychological approach may be important to fit in with women's expectations.

Conflict of interest: none declared.

Implications of this study for general practice

- Perinatal depression was not common as measured in this sample.
- Women find it hard to recognise in themselves.
- Routine inquiry about mood, anxiety and coping will help identify many otherwise undiagnosed.
- Postnatal women and GPs have different ideas of postnatal depression, and how it should be treated.
- This may make psychological and social interventions more acceptable.

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