The period following childbirth is a high-risk time for womens mental health. Postnatal depression and puerperal psychosis may have severe consequences. Screening for depression can identify more women in need of help.

The happiest time in your life?

Postnatal depression deserves our attention for many reasons. What is often expected to be "the happiest time in your life» is certainly not always so. The wide disparity between expectation and actuality may raise the threshold at which women report disorders and symptoms. There is scarcely any period in a woman's life when the need for good caring ability is greater than after childbirth. With depression, particularly if it is severe, the failure to function can have an effect on her ability to care for the child, disrupt the communication between mother and child and affect the whole family. Studies have shown that fewer than one in three cases of postnatal depression are identified (1).

An article in this issue of the Journal of the Norwegian Medical Association describes experience with a screening instrument for postnatal depression (2). The Edinburgh Postnatal Depression Scale (EPDS) was developed in the UK in the 1980s and has since been translated into numerous languages and introduced into clinical use in many parts of the world. There has also been experience of using this tool in Norway. The article emphasises interpretation, when the screening should be undertaken, and limitations compared with a clinical diagnostic interview. Key points include the risk of false positive results and the risk of overlooking a depressive condition, depending on where the threshold value is set.

It is important to differentiate from other conditions with affective symptoms following childbirth, such as postpartum blues. The condition is not classified as an illness and for 26–85 % of women it occurs in the first two weeks after childbirth, and is most pronounced four to five days after birth (3). If the condition is pronounced and long-lasting, there is an increased risk of postnatal depression (1).

Postnatal depression is a relatively frequent condition, but in the period after childbirth there is also a risk of psychosis. Puerperal psychosis normally occurs within the first three weeks in approximately one in 1 000 births (4). In cases of severe affective disorder following childbirth, there is an increased risk of suicide throughout the first year. The puerperal psychosis is in most cases an episode of a bipolar illness, first documented in a Norwegian study from 1966 (5). Psychosis often has a sudden onset after childbirth, is frequently dramatic and more seldom overlooked (6).

Women who have depressive symptoms, but do not fulfil the formal criteria for depression, may still have symptoms with considerable impact on their level of functioning. Recent research demonstrates that subclinical depression can also affect the interaction between mothers and their infants, as shown in a Norwegian study (7). Moreover, the EPDS scale was used in this study (8). Disruptions in mother-child interaction are prominent symptoms in 10–25 % of the women referred for psychiatric treatment after childbirth (9). With good treatment these symptoms can be completely reversed.

Women who are diagnosed with postnatal depression may require treatment and follow-up. While some have mild, short-term depression which often reverses without treatment, some may develop severe, long-term or recurrent symptoms of depression. It is particularly important to identify these women and provide them with a treatment programme that accommodates the woman herself, the child and the rest of the family. Effective treatment is available, and there is reason to communicate optimism regarding treatment outcome (10).

A higher incidence of postnatal depression is reported in developing countries than in industrialised countries, and also more serious consequences (11). Children of depressed mothers in developing countries have slower growth than others (11). When postnatal depression in women is treated, the child's health and nutritional status can also be improved. Mothers who develop depression after childbirth represent a significant global health problem. Effective low-threshold interventions can have great significance.

One effect of training in and use of psychometric instruments such as the EPDS scale is that health personnel are made aware of what symptoms to look for, in order to improve their clinical practice. Routine EPDS screening to identify postnatal depression has been recommended by professionals for a number of years (8, 10). There is also a need for low-threshold interventions for women with moderate symptoms.

A reduced length of stay in the maternity ward, limited network support and the need for rapid diagnosis and intervention means that the child health centres can play a key role in safeguarding women who are struggling mentally after childbirth. This may involve regular interviews with and follow-up from the public health nurse, including home visits. It is necessary to work with the child health centre doctor or GP where there is a suspicion of more severe depression or psychosis. The most serious cases should be referred to the specialist health service, and the time factor is crucial. Postnatal depression is well suited to cross-disciplinary cooperation. There is a need for increased competence and more systematic safeguarding of mothers with mental health problems at Norwegian child health centres (2). Good work here will also safeguard children and might be an effective intervention with regard to child protection.

Based on personal clinical experience and that of others, the prognosis for postnatal depression is often good, given the correct treatment. One consequence of screening is that more cases of postnatal depression are being discovered and effective treatment can be offered.

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