What should be done about postnatal depression in Hong Kong?

DTS Lee, TKH Chung

Postnatal depression is one of the most common forms of psychiatric morbidity of child-bearing and causes a host of adverse psychosocial complications to the mother, the children, and the family. Recent studies have shown that 12% of local women have postnatal depression and most of them receive no meaningful medical attention. The validation of a local version of the Edinburgh Postnatal Depression Scale has made systematic screening for postnatal depression feasible. However, such a screening programme must be backed up by well-resourced counselling and psychiatric services. Much remains to be done if a reasonable level of post-partum psychological care is to be provided. Additional funding is required to train nurse counsellors and set up postnatal mental health teams, as well as mother and child units.

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Introduction

Postnatal depression is one of the most common forms of psychiatric morbidity of child-bearing and affects between 10% and 15% of recently confined women.[1-3] The condition causes psychological distress and emotional torment to the new mother and her family at a time of anticipated joy and can take away a mother's confidence in her ability to care for her baby. Postnatal depression also often causes misunderstanding and tension within a marriage and may ultimately lead to estrangement or divorce. The cognitive and emotional development of the baby may also be adversely affected; the effects may persist into late infancy and early childhood.[4] Women with postnatal depression may even commit suicide and/or infanticide.[5]

Only one in 10 women with postnatal depression is identified and referred for psychiatric treatment.[6] If the condition remains untreated, one third of cases will persist beyond the first postnatal year and a fifth beyond the second postnatal year.[7] Yet, despite being a prevalent disease that has a potentially malignant course, postnatal depression has not, until recently, attracted the attention of the public or the medical profession.

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Misunderstanding and denial

Postnatal depression has been ignored in the past for a number of reasons. Firstly, it is common for a depressed mother, her family, and sometimes even her doctors to misinterpret symptoms of depression (eg low mood, tearfulness, irritability, insomnia, and poor appetite) as being a 'normal' experience of motherhood or an adjustment in reaction to perpetual sleep deprivation and physical exhaustion. This misunderstanding is perhaps not so surprising, given that mental health issues are poorly covered in most antenatal classes in Hong Kong. Secondly, because of the inherent stigma of mental illness, mothers who are conscious of their depression may fear that they will be labelled by their family and friends as "mad and bad" and not fit to take care of a child.[8] Hence, an affected woman may conceal her feelings and try to appear normal to her family and friends. Sometimes, the spouse and family may also collude with the denial to avoid bringing stigma to the family. This fear, together with self-denial, often prevents the woman from seeking treatment.

Recognising depression in the primary health care setting remains suboptimal. For instance symptoms

of postnatal depression, such as insomnia, are seldom discussed in postnatal check-ups. This is because generally, doctors are often predominantly trained to recognise severe psychotic disorders; hence, most of the less severe forms of mental illness usually go unrecognised. On the other hand, general practitioners and obstetricians rightly complain about the often inadequate response of psychiatric services to their referrals when they do identify women who require treatment. If prompt psychiatric consultation cannot be provided to mothers who are identified to have postnatal depression, a screening programme (which would identify approximately 6000 cases per year in Hong Kong, based on a prevalence of 10%)[9] seems wasteful.

Undoubtedly, the government should address the ongoing neglect of the morbidity of postnatal depression. The continued scarcity of specific resources and services for depressed mothers is incongruous with the image of an advanced society that Hong Kong has. Hong Kong has been praised for having one of the lowest maternal and perinatal mortality rates in the world[10] and being one of the best among Asian societies in terms of women's education and workforce participation. Nevertheless, gender-sensitive health care and social policy require more attention. Those who allocate health care resources may not have been properly informed of the scope of the problem, the magnitude of the service needs, and the cost of not treating women who have postnatal depression.

Postnatal depression in Hong Kong: recent developments

Until recently, there has been little methodologically sound research on postnatal depression in Hong Kong. Chen et al[11] have shown that, compared with women in western societies, Chinese women generally have a lower incidence of depressive illness. An anthropological study has even claimed that because abundant social support is available for the traditional post-partum custom of *zuoyue*, commonly translated as "doing the month", Chinese women do not suffer from postnatal depression.[12] However, we have recently shown that postnatal depression among Chinese women is more common than previously believed, and as many as 12% of local women are afflicted with this disabling condition.[9] A large-scale epidemiological study is currently underway and will provide a more accurate figure for the prevalence of the condition and identify the service needs in the community.

An important advance in the service for postnatal depression is the application of the Edinburgh Postnatal Depression Scale (EPDS), which is a 10-item self-report rating scale designed for the early detection of postnatal depression.[13] The EPDS is simple, inexpensive and easy to use; it has been widely applied by health visitors in the United Kingdom to screen for depressive illness in postnatal follow-up visits. A local Chinese version of the EPDS has recently been validated and is obtainable in the public domain.[9,14] We have found that when applying the Chinese EPDS in the local population, a cut-off score of 9.5 is more appropriate than the commonly quoted cut-off value of 12.5.[9] It is also important to appreciate that the EPDS has never been intended to be a diagnostic instrument. An EPDS score of >9 only indicates a substantial probability of postnatal depression in the respondent and that further comprehensive assessment is required. The EPDS cannot, and should not, be used as a substitute for proper clinical evaluation.

Another advance due to postnatal depression research in Hong Kong is a better cultural understanding of the traditional post-partum custom of *zuoyue*, which used to be regarded by western researchers as a unitary, integrated, all-or-none post-partum practice.[12] In fact, *zuoyue* is merely a general term to describe numerous traditional health beliefs, taboos, rituals, and proscriptions in relation to how a Chinese woman should behave in the immediate month after childbirth. Few contemporary women would adhere to all practices, and indeed some practices, such as not bathing, may no longer serve their original intention and are now seldom practised. While it is sensible for local health care professionals to advise against those traditional post-partum beliefs and practices that are outdated and inappropriate, one should also be aware that some traditional post-partum beliefs and practices may still be useful and should be encouraged and perpetuated. A notable example is the custom of *peiyue*, which stipulates that a recently delivered woman should be accompanied and attended by an elder female relative. This practice ensures adequate practical and emotional support, and enables child-rearing skills to be passed on to the new mother. Non-passage of skills and inadequate social support have been suggested as causes of postnatal depression in industrialised societies.[15] We have recently shown that women who practise *peiyue* receive better support and have a lower degree and prevalence of postnatal depression.[16] The next logical step would be to identify factors that enhance the quantity and quality of the *peiyue* interaction and to devise programmes and services that functionally simulate *peiyue* for women who do not have access to this practice.

More research on postnatal depression in Hong Kong is in progress and two community-based post-partum support groups have been established. The mass media is generally more aware of and concerned about the occurrence of postnatal depression and its potential severe consequences. In many instances, suicides and infanticides have been judiciously and accurately reported to the public. The sensible representation of postnatal depression in television series and soap operas has not only heightened public awareness, but also demystified and legitimised a common morbidity of child-bearing.

What should be done about postnatal depression?

Given that postnatal depression is common and serious, and that most affected women receive no meaningful medical attention, it would seem logical to have a territory-wide policy to screen all recently confined women. Such a screening programme would ideally be a part of the routine post-partum maternal check-up. As the EPDS is inexpensive, simple, and easy to administer, using this screening procedure would require only minor adjustments of clinical practices and budgets. A screening programme utilising the Chinese version of the EPDS has been implemented at the Prince of Wales Hospital since 1 August 1998. The questionnaire is administered mainly by midwives, who have responded to this initiative with great diligence and enthusiasm. The programme has been well received, and severely depressed women have already been identified and successfully treated (unpublished data).

However, as is the case at the Prince of Wales Hospital, screening programmes often threaten to overwhelm existing psychiatric services. Thus, territory-wide screening programmes should be supported by responsive psychiatric services. A screening programme will potentially identify 80% of cases of postnatal depression,[9] compared with approximately 10% that are currently recognised in Hong Kong. Of the women identified to be depressed, approximately 60% would agree to some form of intervention (unpublished data). Half of the cases of postnatal depression (about 1500 per year) will meet the criteria of major depression and hence require psychiatric attention. It is doubtful, however, that the existing psychiatric service, which is already overloaded, can cope with the additional cases of major depression. Designated postnatal mental health teams and out-patient clinics should be established in most catchment units in Hong Kong. These teams should be led by specialist level general adult or liaison psychiatrists and be staffed with midwives, community psychiatric nurses, medical social workers, and occupational therapists to meet the multidimensional needs of mothers with postnatal depression.

In Hong Kong, nursing staff are beginning to give formal psychological counselling to women who have psychosocial problems. For example, midwives in at least one Hospital Authority hospital are already providing specific grief counselling to women who have experienced stillbirth or perinatal death. In the United Kingdom, clinical trials have shown that health visitors can give effective client-centred counselling or cognitive behavioural counselling to women with postnatal depression.[17-19] Likewise, local midwives, given appropriate training, would be able to operate a counselling clinic at a hospital obstetrics department to treat postnatal depression; the treatment does not require antidepressants or intensive psychiatric monitoring. This approach will provide better job satisfaction for the nurses, lessen the workload of medical clinicians, and minimise the stigma for patients and their families. In addition, such a service is less expensive to operate and is more affordable to the local society.

An indispensable component of any perinatal mental health service is the mother and child unit. At present, when in-patient treatment is required for severe postnatal depression, the clinician and the family usually have only one option: to separate the mother and the newborn baby. This obviously contributes to reluctance to receiving, and sometimes delay in instituting, in-patient care. Not only does maternal-infant separation sever the bonding process, but having the mother admitted to hospital also means having to find a relative or friend to care for the newborn, which is often neither easy nor straightforward. At times, a newly born infant is admitted to a children's home of the Social Welfare Department, which adds further distress to the patient, the family, and the clinician. Having mother and child units can help avoid these problems. To avoid unnecessary stigma, these units should not be situated in psychiatric wards but in designated areas of postnatal wards or, even better, in designated wards of regional general hospitals.

Conclusion

Hong Kong has much to do if a reasonable level of post-partum psychological care is to be provided. Indeed, these services should be as sensitive to the psychological needs of women during their pregnancy

as after childbirth, because the greatest predictor of postnatal depression is antenatal depression. Recent studies have already confirmed the scope of unmet psychological needs of confined women and the substantial hidden morbidity in our society. Methodologically sound systematic screening for postnatal depression is now feasible. However, postnatal screening to detect depressive illness must be supported by well-resourced perinatal mental health services, and additional funding will be required for training nurse counsellors, setting up perinatal mental health teams, and establishing mother and child units.

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