This is also good news but presents yet another dilemma. Once a patient has the good fortune of responding to combination treatment and leaving the hospital improved, the questions loom of when and if to taper one agent in the combination and strive for monotherapy for maintenance treatment. Only two randomised controlled studies compare combination treatment with maintenance treatment of bipolar disorder with monotherapy.[11 12] Both found combination treatment superior to monotherapy in preventing relapse, although, not surprisingly, at the cost of a greater burden of side effects.

The treatment of acute mania cannot really be considered in isolation from the long term or maintenance treatment of bipolar disorder, and it is at this interface that we lack much needed data. The field is poised for longer term effectiveness studies of combination treatment, enrolling manic patients who are more broadly representative of clinical populations.

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Treatment of postnatal depression

Effective interventions are available, but the condition remains underdiagnosed

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Major depressive episodes after childbirth are referred to as postnatal depression or, in the United States, as postpartum depression. During the first six months after delivery the prevalence of major depression is estimated at 12-13%.[w1] The precise time frame for defining postnatal depression has varied across studies, typically from one month to one year after childbirth. In an effort to standardise the terminology, the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition, restricted the specifier of postpartum onset to depressive episodes occurring within four weeks of delivery. However, most studies of postnatal depression have continued to use wider time frames, in part because epidemiological studies show that women's heightened vulnerability to depression continues for at least the first six months after childbirth. Postnatal depression must be distinguished from postnatal blues ("baby blues"), a common experience following childbirth, in which new mothers experience lability of mood and tearfulness. This mild and self limiting condition typically disappears two weeks after delivery.

Unfortunately postnatal depression is often overlooked in primary care clinics. In a study of 214 women who brought their children to a general paediatric clinic, 86 reported high levels of depressive symptoms on the psychiatric symptom index. Of these women, only 29% were identified as depressed by the paediatricians.[1] The mother's suffering, coupled with the burden that her depression places on the family and the potential detrimental impact on the relationship between mother and child and the child's cognitive and social development,[w2] call for prompt and effective methods of screening for postnatal depression. Once identified many, if not most, patients with postnatal depression can be treated in primary care settings.

Surprisingly, only one randomised study has evaluated the pharmacological treatment of postnatal depression.[2] The study entailed a comparison of four treatment groups (total n = 87): fluoxetine plus a single session of cognitive behaviour therapy; placebo plus a single session of cognitive behaviour therapy; fluoxetine plus six sessions of cognitive behaviour therapy; and placebo plus six sessions of cognitive behaviour therapy. After four weeks of treatment, similar improvements occurred among women receiving either six sessions of cognitive behaviour therapy, or fluoxetine plus one session of cognitive behaviour therapy. The study shows that women's choice of treatment may be guided by their preference of pharmacological or non-pharmacological approaches as both seem comparably effective.

Several studies have reported that antidepressants, including sertraline, paroxetine, venlafaxine, and nortriptyline, can be used safely by nursing mothers of healthy full term infants.[3 4w3 w4] Fluoxetine has been

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linked with irritability, sleep disturbance, and poor feeding in some infants exposed to it in breast milk, although other reports have not noted adverse incidents.[5] Although the data regarding antidepressants during breast feeding are generally favourable, little is known about the long term effects of exposure to antidepressants on the child's developing brain. Many new mothers remain reluctant to take such medications while nursing.[2]

On the other hand several studies have found that psychotherapeutic interventions for postnatal depression are highly acceptable. One randomised study evaluated the use of interpersonal therapy, a time limited psychotherapy focusing on interpersonal relationships and role transitions.[6] Ninety nine depressed new mothers were randomised to 12 weeks of interpersonal therapy or to a waiting list control group. Women receiving interpersonal therapy were more likely to recover from their depressive episode than women in the control group (44% *v* 14%). In a second study 48 new mothers with postnatal depression were randomised either to five to eight weeks of cognitive behaviour therapy at home or to a control group.[7] Recovery rates were higher in the treated group than the control group.

Additional studies have explored the use of supportive psychotherapy at home for depressed new mothers. In a randomised trial of 50 women within three months of delivery, counselling by paraprofessional healthcare workers led to full recovery in 69% of the treatment group compared with 38% of the control group.[8 9] The healthcare workers, who had received a brief training in non-directive counselling, visited the mothers at home for half hour sessions over eight weeks. A second randomised study of six weeks of visits for non-directive counselling by nurses similarly found high rates of recovery in the intervention group (80%) compared with the control group (25%).[10] For harried new mothers who may not be able to attend psychotherapeutic sessions regularly, therapy at home has obvious advantages. Its efficacy compared with outpatient psychotherapy and pharmacotherapy requires further study.

However, the largest study that compared different psychotherapeutic approaches for postnatal depression found little benefit at nine months after birth.[11] In this study, 93 women with postnatal depression were randomised to routine primary care, non-directive counselling, cognitive behaviour therapy, or psychodynamic therapy.[11] Only the psychodynamic therapy produced a clinically more significant reduction in depression compared with the control group at 4.5 months, and by nine months none of the treatments seemed superior to the control group. The control group may have experienced a higher recovery rate than expected because of the attention they received in the recruitment and assessment process. Nevertheless, the study underscores the importance of further research comparing alternative treatment approaches for postnatal depression.

The usefulness of transdermal oestrogen for postnatal depression was evaluated in a study of 61 women with major depression beginning within three months of childbirth.[12] After one month of treatment, mean scores on the Edinburgh postnatal depression scale among women receiving oestrogen were lower than those of women receiving placebo, although the scores in both groups remained elevated (more than 13), implying that the effect of oestrogen was modest. Its usefulness for postnatal depression is compromised further by the problems associated with its use, which include potential endometrial hyperplasia, thromboembolism, and a diminished supply of breast milk.[w5] No randomised studies have evaluated the usefulness of natural progesterone for postnatal depression.

Small open studies have reported that alternative approaches, including bright light therapy, massage, and relaxation training, produce improvements in postnatal mood. These interventions merit further research as they are well tolerated and safe. Also worthy of further research is St John's wort, currently the most widely used herbal supplement in the treatment of depression. New mothers may mistakenly assume that St John's wort is safe to use during nursing because it is "natural." Data on its safety during breast feeding are too limited to recommend its use by nursing women.

Postnatal depression is a highly treatable condition. A variety of interventions, including antidepressants and psychotherapy, can be helpful. New mothers need not discontinue breast feeding if they initiate certain antidepressants. A principal challenge remains in more effectively screening for and identifying this common diagnosis. Also, further studies are needed to compare treatment approaches and assess preventive and follow up interventions.

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