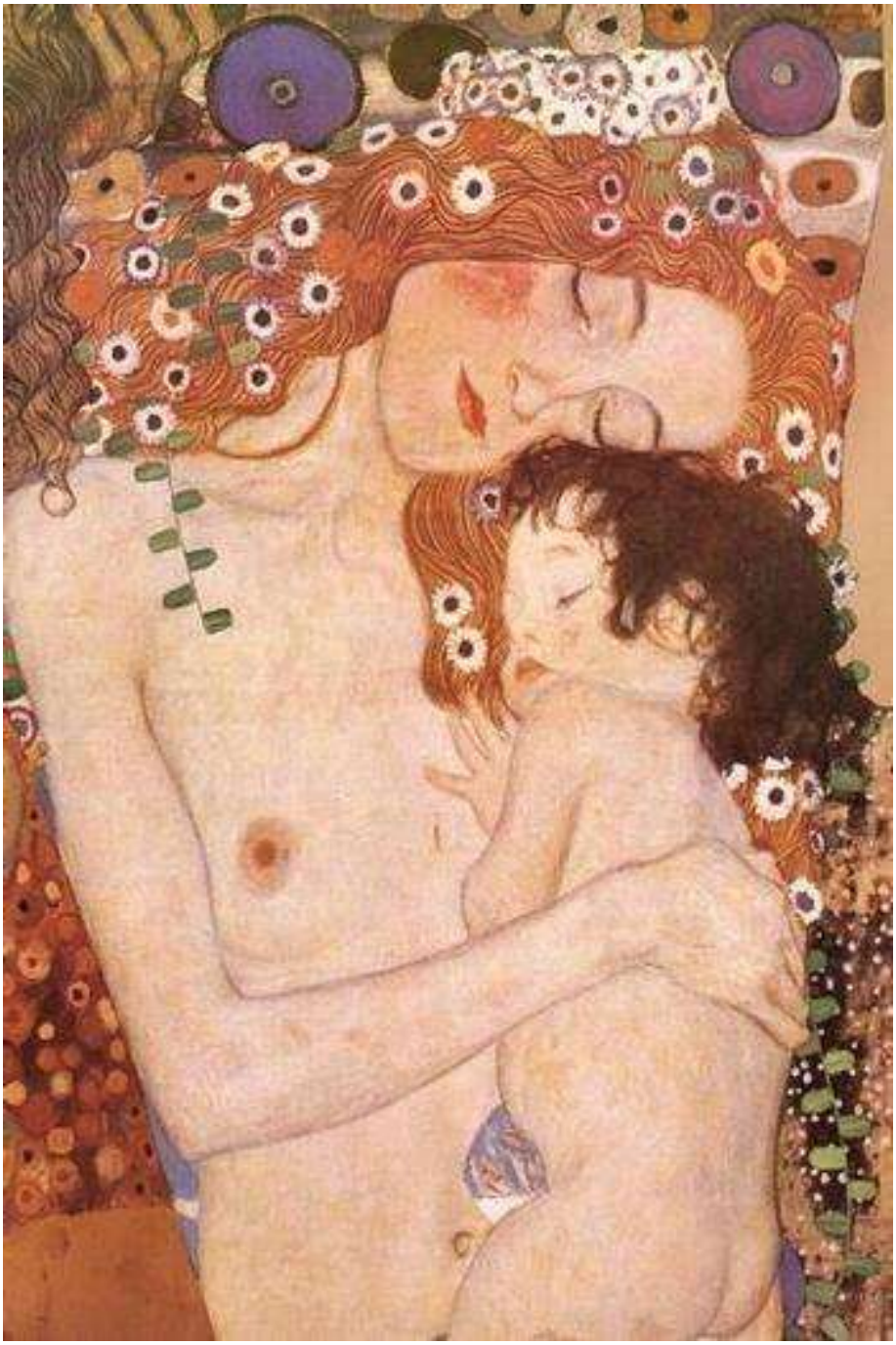
THE NORTHERN HOSPITAL

# PERINATAL DEPRESSION



*"Mother and Child" (detail from The Three Ages of Woman), Gustav Klimt c.1905*

# PERINATAL DEPRESSION

## Introduction

**Postnatal depression** is a well recognized term, however the term **perinatal depression** is probably a more accurate description as depression often begins antenatally, but often goes unrecognised until the postnatal period.

Women are commonly reluctant to seek help, however early identification and intervention are essential in order to minimise **longer term complications.**

Although there is a somewhat limited evidence base, medication, cognitive behavioural and interpersonal strategies and support are though to be of use.

*Early* identification is through:

- Careful assessment of the patient
- Assessment of her infant
- A knowledge of the known risk factors
- An awareness of the difficulties women have in recognising and accepting a diagnosis of depression.

This assessment may occur during *perinatal period and* not be confined purely to the post-natal period.

Those identified as depressed or significantly at risk in the ED setting should be referred immediately to the ED CATT.

## Epidemiology

Perinatal depression is a common disorder:

- Milder adjustment problems and anxiety affect some 30% of perinatal women
- About 15% of women have more significant mood disorders, often with associated anxiety.

## Pathology

Historically, pregnancy was considered to be protective against mental illness and suicide, however this now known to be false. Mental illness is just less likely to be recognised in pregnancy.

*Risk factors for perinatal depression:*

**High correlation with increased risk:**

- Depression in pregnancy
- Past history of affective disorder
- Family history of affective disorder
- Lack of support - partner, mother
- Multiple stressors
- Women with previous perinatal depression or psychosis are particularly at risk of having another episode with future pregnancies.

**Some correlation with increased risk:**

- Perfectionist personality
- Low socioeconomic status
- Aboriginal and Torres Strait Islander people
- Childhood abuse

*Complications:*

*The longer term complications of perinatal depression can be significant and for the mother may include:*

- Suicide
- Chronic depression
- Marital difficulties

*and for the child may include:*

- Cognitive problems
- Emotional problems
- Behavioural problems.

## Clinical assessment

Unless women have previously had depression, they rarely recognise it in themselves during the perinatal period.

Women may seek help for the baby, not for themselves.

Postnatally, there are a number of reasons why women do not seek help:

These include:

- The presence of predominant anxiety rather than depression
- A mistaken belief that postnatal depression is somehow linked to not wanting the baby or being a bad mother
- The stigma of being seen as a bad mother
- The stigma of depression.

It is important to assess the patient for the known risk factors of perinatal depression, in order to help stratify the risk, (see above).

Ideally, this risk should be detected during pregnancy rather than following delivery.

Screening for depression with tools such as the Edinburgh Postnatal Depression Scale can be helpful, (see separate Edinburgh Postnatal Depression Scale Screening Tool). Many antenatal clinics and maternal child health nurses do screening and suggest women with scores > 12 see a doctor.

Women with depression generally have symptoms which last longer than two weeks.

They usually have significant anxiety (often related to the baby and their ability to mother), tearfulness, and feel easily overwhelmed and unable to cope with even basic household chores.

Biological symptoms (insomnia, appetite changes) not accounted for by disturbed sleep and breastfeeding also suggest a more serious disorder.

**The severity of symptoms and their impact on the woman's life are the best guides to the need for intervention.**

### *Differential diagnosis*

Depression should be distinguished from the less common **postpartum psychosis.**

The latter usually presents in the first few weeks after birth, with confusion, dramatic mood or psychotic symptoms, and requires urgent assessment and inpatient treatment.

## Management

The main task in the ED will be to identify those with significant perinatal depression or those who are at risk.

Those patients identified should then be referred to the ED CATT for further assessment.

Intervention will need to be *urgent* when self harm or harm to a child is possible

Interventions may include the following:

1. Psychosocial interventions.

2. Social supports:

   - It is important to also consider supports such as child care

   - Maternal and baby health services, including inpatient education/ respite services.

3. Psychologist:

   - This may be appropriate where the is significant associated anxiety.

4. Antidepressant medication:

   These are not generally prescribed directly from the ED. They are best prescribed by and after assessment by the psychiatric unit

   Whilst there are risks with antidepressants in pregnancy it is important to balance these with the risks of **not** treating depression for any given patient and any given drug. Whether or not the mother is breast feeding will also need to be considered.

   **In general the indications for consideration of antidepressants for perinatal depression include:**

   - Severe or significant number of symptoms, particularly biological symptoms (e.g. sleep and appetite disturbance)

   - Persistent symptoms

   - Response to psychosocial management is inadequate

   - Unable to offer psychosocial management because of cost, distance, or other practical factors

   - Family or past history of good response to medication

- Woman’s preference

5. Psychiatric assessment and hospital admission:

   Most women with perinatal depression can be managed as outpatients.

   Admission may be required in cases of:

   - High risk of, or actual, self harm
   - High risk of, or actual, harm towards the infant
   - Extreme anxiety and inability to cope

## Appendix 1

*Patient support resources*

**Beyond Blue:**

- Website: www.beyondblue.org.au
- Telephone information line: 1300 22 4636

Beyondblue is an Australian independent not-for-profit organisation working to address issues associated with depression, anxiety and related substance misuse disorders.

**Post and Ante Natal Depression Association (PANDA):**

PANDA is a Victorian not-for-profit self-help organisation that provides confidential information, support and referral to those affected by post- and antenatal mood disorders, including partners and extended family members.

- Website: www.panda.org.au
- Telephone: 1300 726 306 Victoria, (03) 9481 3377 outside Victoria

*References*

1. Professor Anne Buist, "Treatment of perinatal depression", Aust Prescr 2008; 31:36–9.

Dr J.Hayes
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