South Australian Perinatal Practice Guidelines

Perinatal anxiety and depressive disorder (including postnatal depression)

Introduction

- Anxiety and depressive disorders are common in the perinatal period (conception to 12 months post-natal should be considered where possible as mental health problems are common throughout the first year after childbirth), occurring in about 1 in 5 women and women are more likely to develop a mental health disorder during this time of life than any other[1]
- Bipolar mood disorder and puerperal psychosis (considered as a postpartum form of the disorder) are considered separately in these guidelines
- Depression and anxiety often occur together, are often present antenatally and persist if not treated. These disorders can have a wide range of effects for the fetus[2], the infant, partner and other members of the family
- Antenatal anxiety rivals other well known obstetric risk factors in predicting preterm birth, low birth weight and other birth complications[3]
- Perinatal depression and anxiety may be associated with poorer cognitive and behavioural functioning in children, reduced attention span and childhood anxiety
- Maternal death through suicide can be a result of severe mood disorder and ranks equal to obstetric haemorrhage as cause of maternal death in Australia[4]
- It is important to exclude underlying physical problems which present as depression or anxiety or which may make symptoms worse i.e. anaemia, thyroid malfunction
- Recent bereavement or unresolved loss may be a factor requiring separate consideration
- Other contextual factors such as age, history of abuse and cultural factors may impact on the expression of distress and form of help seeking
- Sometimes extreme exhaustion and sleep deprivation may mirror depression and anxiety or may be a risk factor for the development of these disorders
- Anxiety and depression, and the potential consequences for mother, infant and family, will benefit greatly by early identification, support and good clinical management

Risk factors

Psychological

- Antenatal anxiety, depression or mood swings
- Previous history of anxiety, depression, or mood swings, especially if occurred perinatally
- Family history of anxiety, depression or alcohol abuse, especially in first degree relatives
- Severe baby blues
- Personal characteristics like guilt-prone, perfectionistic, feeling unable to achieve, low self-esteem
- Edinburgh postnatal depression score ≥ 12

Social

- Lack of emotional and practical support from partner and / or others
- Domestic violence, history of trauma or abuse (including childhood sexual abuse)
- Many stressful life events recently

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- Low socioeconomic status, unemployment
- Unplanned or unwanted pregnancy
- Expecting first child or has many children already
- Child care stress

Biological / medical

- Ceased psychotropic medications recently
- Medical history of serious pregnancy or birth complications, neonatal loss, poor physical health, chronic pain or disability, or premenstrual syndrome
- Perinatal sleep deprivation
- Neonatal medical problems or difficult temperament[5]

Where risks are identified, document details about the nature and degree of risk in the case notes

Diagnosis

Major depressive disorder - criteria

- Depressed mood
- Anhedonia – loss of the capacity to experience pleasure
- Unexpected change in weight or appetite
- Markedly increased or decreased sleep-typically mother cannot get back to sleep after baby wakes and is settled and ruminates
- Fatigue or loss of energy
- Feelings of worthlessness and guilt
- Reduced concentration
- Recurrent thoughts of suicide or death
- Physical agitation or slowing (psychomotor retardation)

Symptoms must be present and persistent for at least two weeks

Other relevant factors in severe depression postpartum

- Mothers may also report obsessive thoughts or images about harming their infant. Guilt and shame can prevent them talking to family or professionals and thereby receiving help
- Obessional thoughts of infant harm which are alien to the woman's desires and persona must be distinguished from mothers who are delusional (psychotic) or

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severely depressed who are often suicidal as well as expressing infanticidal thoughts. The latter women may also have plans to harm themselves and / or their infants. These infants are clearly at great risk (See PPG 'Psychosis in pregnancy and postpartum')

Borderline Personality Disorder (complex trauma)

- Women with this personality style[6,7] may also become depressed but on a background of chronic mood instability (particularly anger), impulsivity, interpersonal difficulties and deliberate self harm
- These mothers often have difficulties managing their infants particularly with soothing and settling; they may become very anxious and overwhelmed easily with caretaking tasks[8]. They are perhaps more likely to harm their infant than other women

Dysthymic disorder

- Some women report chronic low grade depressive symptoms that persist for years and can substantially interfere with their quality of life, attachment to their infant and parenting but may go unrecognised without specific enquiry
- Thus, women may enter pregnancy with chronic depression which will interfere with not only their own functioning and at times, views of their pregnancy, but also is now known to impact on the fetus, for instance in raising serum cortisol9. Thus recognition and active treatment is entirely appropriate (See PPG 'screening for perinatal anxiety and depression')

Substance use

- A significant number of women with mental health concerns including depression and anxiety also use substances either as a way of reducing symptoms or as a secondary effect of substance misuse
- It is always important to ask about use of tobacco, alcohol and other drugs and to offer advice and referral to specialised services if needed as these women and their infants are at high risk for poorer outcomes
- For further information, refer to the PPG 'substance use in pregnancy'

Anxiety Disorders

- These can take different forms. Generalized Anxiety Disorder - persistent and excessive worry of more than 6 months duration, may be more common in post-natal women than the general population[10]
- Fear and phobias may emerge for the first time or be magnified by the normal stressors of pregnancy and childbirth
- Tokophobia-fear of dying in childbirth may cause some women to want to terminate the pregnancy or ask for a caesarean section in attempt to control their fear

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- Anxious women worry more about their infant's health and some fear cot death excessively –frequently unable to sleep when their infants are sleeping
- Panic Disorder is characterised by panic attacks-acute onset of shortness of breath, palpitations, tremor and or dizziness with feelings of dread. This may worsen in the post-natal period with some women becoming agorophobic and socially isolated
- Obsessive Compulsive Disorder may be extremely debilitating post-natally if not under control as women become exhausted performing compulsive behaviours and rituals or become pre-occupied with obsessive thoughts, leaving little time and energy for caring for their infant, themselves or other children. Previously mild symptoms may become exacerbated post-natally
- Post-traumatic stress disorder may arise from a life threatening event during pregnancy or birth (ante or postpartum haemorrhage) or may be pre-existing from earlier life trauma - women who have experienced prolonged childhood abuse especially sexual abuse may present with a complex trauma syndrome which is exacerbated during the pregnancy and post-partum (see PPG 'sexual abuse in childhood: care considerations for women who are pregnant')

Management

- Good treatment starts with early detection either by the woman herself identifying the problem or else via screening in pregnancy which can occur with the Edinburgh (postnatal) depression scale (EDS), history taking and psychosocial screening (see in PPG 'screening for perinatal anxiety and depression')
- If symptoms are present treatment can be suggested through a woman's GP or other health counsellors and / or a mental health care plan can be made with referral to a psychologist or direct referral to mental health specialist if more severe
- In South Australia all metropolitan maternity hospitals have access to specialised perinatal mental health services who offer consultation and liaison with midwifery and obstetric staff
- There are many issues associated with management of depression and anxiety, with problems related to decisions to treat and also to not treat[11]

Prevention and early identification and intervention:

- At this stage the evidence for preventing perinatal depression and anxiety before it starts is scant and has included ante-natal education classes and groups for at risk women, anti-depressants, fish oil, vitamins and minerals etc
- Simple measures for mild depressive or anxiety symptoms may include ensuring women get enough sleep, rest and social support, regular exercise, adequate diet, access to support for parenting, practical help in the home and PND support groups
- Long term family home visits by nurses such as offered by CFH Services to some women following universal postnatal visits in SA are helpful to promote the

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attachment relationship with her infant which can be affected by maternal mental illness

- More severe disorders may require mental health interventions, i.e. medication (link to psychotropic meds in pregnancy and post partum), cognitive behaviour therapy and interpersonal therapy and if severe hospitalisation in Helen Mayo House –the statewide mother baby unit (telephone 08 83031183)
- The latter is imperative whenever suicidal or infanticidal ideation is present in the context of depressed mood, and / or when there is a delusional mood disorder
- These women and their babies (and partners) will often need specialised parent-infant therapies as well (Advice on availability through Helen Mayo House on 08 83031183 or 08 83031425)
- Efforts should be made to ensure that mothers and infants remain together whenever safety factors permit this, particularly with younger infants
- Suicidal thoughts: Midwives and medical staff should always ask women who are depressed about suicidal thoughts and plans in as matter of fact way if possible (see PPG 'suicidal ideation and self harm')
- In particular they should enquire as to whether it is likely plans will be carried out (are they active?) and whether the woman has the means to do this as well level of impulsivity and control over her thoughts / impulses
- Consultation with mental health services should be sought immediately if there is active suicidal thinking
- Partners - can also suffer from perinatal depression and anxiety either secondary from the stress of managing the mother's symptoms or as a primary problem[12]
- It is important to assess a partner's mental health and their understanding of the mother's distress as well as any relationship difficulties arising from mother's depression or which maybe compounding her depression

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Acknowledgements

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Resources

Beyond blue. Available from URL: http://www.beyondblue.org.au/index.aspx?

CYWHS Perinatal and Infant Mental Health Services at WCH and Helen Mayo House (State-wide service)

Lyell McEwin PIMHS

Flinders Medical centre

CYWHS-CAFS

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Abbreviations

CFH	Child and Family Health
EDS	Edinburgh (postnatal) depression scale
e.g.	For example
et al.	And others
GP	General Practitioner
KEMH	King Edward Memorial Hospital
PND	Postnatal depression
SA	South Australia

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