

Antenatal and postnatal mental health:

An NCT Evidence Based Briefing

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"I don't like me any more, I always seem to be worried, I used to be so capable, now I just sit and cry all the time."

This briefing describes changing emotions and mental health issues before and after childbirth. It addresses the range of mental disorders that can affect women in pregnancy and the postnatal period. It reviews the evidence on the identification and treatment of psychosis and serious depression and then explores the impact of depression and anxiety on women, their children and their partners. It addresses the causes and risk factors for depression, strategies for prevention and identification of depression and anxiety, and treatment options.

Search Strategy

In addition to the author's professional knowledge of the subject matter, the information in this briefing has been derived from a number of sources. These include the NICE guideline on antenatal and postnatal mental health and the evidence that informed the guideline, information and research published by mental health charities and relevant professional organisations, a manual search of professional journals and general web search using terms "antenatal", "postnatal", "perinatal" + "mental health", "mental illness", "mental disorder", "mood disorder" "depression", "anxiety", and web forums for women with antenatal and postnatal mental illness.

Changing emotions and mental health

The transition to motherhood is experi-

enced by most women as a time of emotional change and challenge. External changes in a woman's physical shape, in her occupational status, and in her relationship with her partner may be mirrored by internal changes in her sense of self-esteem and self-efficacy. Although these changes may be positive and a source of happiness, many women across a wide range of cultures experience transient periods of low mood during pregnancy or after a baby's birth, including feelings of loneliness, increased anxiety and unhappiness. For most women these feelings are relatively mild and would not lead to a clinical diagnosis of mental disorder if help were sought. They tend to resolve as a woman adjusts to her new maternal role, depending on her history, general well-being and sources of support. For a minority of women, however, this low mood has a significant impact and may amount to a clinically diagnosable mental disorder.

Mental disorders during the antenatal and postnatal period take many forms. There is a lack of professional consensus about whether different disorders are part of a spectrum or are entirely separate conditions. Everyday terms such 'depression' or 'anxiety' are used to describe some of them, but there is a risk that the familiarity of these terms can lead to an underestimation of the severity of their effects.² The picture is further complicated by the historical tendency to under-diagnose antenatal mental disorders and to blur together all postnatal mental disorders under the label of 'postnatal depression'.³ Current thinking distinguishes the following perinatal mental disorders:

Baby blues

A brief period of low mood, anxiety and tearfulness after the birth of a baby, with symptoms peaking on the fifth day,⁴ affects the majority of new mothers (estimates range up to 85%).⁵ A woman experiencing the blues needs support and reassurance but not treatment.⁶ The National Institute for Clinical and Health Excellence (NICE) guideline on postnatal care recommends that new mothers should be encouraged to look after their mental health by looking after themselves, and that if the symptoms have not resolved by 10-14 days after birth, the woman should be assessed for postnatal depression.⁷

Depression

Rates of depressed mood in pregnancy appear to be higher than the rates postnatally,⁸ and many women who suffer from antenatal depression have experienced depression before pregnancy as well.

An estimated 10-15% of new mothers are affected by mild postnatal depression, usually manifesting within the first three months after birth.⁹ Symptoms include tearfulness, irritability, feelings of loneliness, loss of confidence, and a lack of satisfaction with motherhood.¹⁰ Some 3-5% of new mothers develop moderate to severe postnatal depression, usually within the first four to six weeks after birth.¹¹ The risk of developing severe depression is five times higher than normal in this postnatal period, and two per thousand new mothers are admitted to hospital because of it.¹² Symptoms of severe depression include low mood, impaired concentration, extreme tired-

ness, feelings of guilt, incompetence, hopelessness and despair, and morbid thoughts about oneself or the baby.¹⁰

Anxiety

Anxiety and depression often occur together, before, during and after pregnancy, and each condition appears to worsen the symptoms of the other.³ Rates of generalised anxiety disorder may be higher during pregnancy than in the postnatal period.¹³ At the milder end of the anxiety spectrum, a woman feels overwhelmed by her responsibilities and unable to cope. At the more serious end, the woman fears she is losing control and going mad, and experiences debilitating panic attacks with palpitations and difficulties breathing that can make her feel she is suffocating and dying. Panic attacks are so frightening that the woman may try to avoid situations or places she associates with an episode, gradually closing herself off from normal activities and in the end from even leaving the house.¹⁴

For some women, anxiety may manifest with obsessive-compulsive symptoms, which is again far more common among women who are depressed.³ A small percentage (similar to the general population) of new mothers experience postnatal Post Traumatic Stress Disorder, which may be related to feelings of disempowerment during a traumatic labour, or may be a pre-existing condition.³ Symptoms include nightmares, flashbacks, anger, and difficulty concentrating and sleeping.¹⁵

Psychosis

There is no particular risk of developing a psychotic disorder during pregnancy, but women with pre-existing psychotic disorders (such as bipolar disorder or schizophrenia) may be at increased risk of experiencing a psychotic episode if they stop taking medication abruptly due to pregnancy.³

About one to two per thousand women experience puerperal psychosis, which is a term used generally to describe all psychotic episodes typically occurring within the first three months after birth. Many of these women have a pre-existing mental

disorder, but some have no history of mental illness.³ A woman is 35 times more likely to develop psychosis during the first month after birth than at other times.¹⁶ Symptoms include delusions, hallucinations, confusion, fear, suspicion, rapid mood swings, and disinhibited and uncharacteristic behaviour.^{6,10}

Apart from the 'baby blues', experiencing any of these mental disorders in the perinatal period can have a serious impact on the mother, her baby, her partner and the family. As a result, there is considerable emphasis within public policy on mental health during this life stage.^{17,18} The consequences of perinatal mental disorders, and the efforts to detect and treat them, are explored below. Much of the evidence base and existing practice focuses on postnatal depression (PND) to the exclusion of other disorders and, although the narrow focus has been condemned as unfortunate by NICE, the lack of evidence on other mental disorders is reflected in the rest of this paper.

Psychosis and other serious mental illness

"With my first baby I was in hospital for three months when she was six months old, because my depression was never taken seriously; I was separated from her and put in a psychiatric hospital. This time the obstetrician and the Sure Start midwife got together with my mental health worker and the head of midwifery, and everyone was talking to each other and trying to set up a room in the hospital where I could go with the baby if I did get postnatal depression, ...so I knew all the things that were scaring me had been taken care of. It's made a huge difference to my well-being – my mental health since I had (my second baby) has been fine."¹¹

Untreated psychosis during pregnancy is associated with preterm birth and low birthweight.^{19,20} The Confidential Enquiry into Maternal Deaths has identified psychiatric disorders as the leading cause of maternal death, predominantly through violent suicide, with White women from comfortable backgrounds at particular

risk of committing suicide.²¹ Women with a history of severe mental illness have a significantly higher incidence of serious postnatal mental illness than other women. In recognition of this, it is a mandatory procedure under the Clinical Negligence Scheme for Trusts for pregnant women to be asked about their previous psychiatric history and family history of mental illness as a routine part of antenatal care,¹⁰ and the NICE guideline on antenatal and postnatal mental health recommends that these questions should be asked at first contact with services in both the antenatal and postnatal periods. Where a woman has a current mental disorder or a history of severe mental illness, she should be asked about her mental health at every contact.⁷

The NSF for Children, Young People and Maternity Services requires that all NHS maternity care providers have in place policies and protocols for supporting women who are at high risk of developing a serious postpartum mental illness, including joint working arrangements with the local Mental Health Trust and direct access by maternity professionals to a perinatal psychiatrist.²² NICE further recommends that where a woman has a current or past history of serious mental illness, a written care plan covering pregnancy, delivery and the postnatal period should be agreed between the woman, her partner, her family and all relevant healthcare professionals, usually in the first trimester.⁷ In practice, despite limited evidence to support it, this may include drug treatment in the immediate postpartum as a preventative measure.^{23,24}

Treatment during pregnancy and breastfeeding

The NICE guideline on antenatal and postnatal mental health emphasises that drugs should be prescribed cautiously during pregnancy and breastfeeding. It recommends that where a woman is affected by serious mental illness or has a history of serious mental illness, health professionals should discuss with her the risks from stopping medication abruptly, the risk of harm associated with drug treatments, the risk of harm from the

i Quote from woman interviewed by author for the National Evaluation of Sure Start qualitative evaluation of maternity services in Sure Start local programmes

mental disorder if untreated, and treatment options that would enable the woman to breastfeed if she wants too, rather than recommending that she does not breastfeed. NICE also gives detailed guidance on the safety of specific drugs.³

Where a woman requires in-patient treatment, she should have access to a Specialist Mother Baby Psychiatric Unit so that she can be cared for without separation from her baby^{22,7} (although the evidence for the efficacy of these units, in relation to certain disorders, has been questioned).²⁵ However, there is not, as yet, sufficient capacity in these units to provide this specialist treatment to all women who require it, and some new mothers with serious psychiatric conditions are admitted without their babies to general psychiatric wards.¹⁰

Depression and anxiety

The lived experience of depression and anxiety

*'It was like being under a huge, black cloud... It's like a huge chunk of my life is missing that I'll never get back.'*²⁶

*'I spent the first few months feeling disappointed and guilty and felt frustrated by the demands of my baby. I had turned into a person I barely recognised. I kept telling myself I should just get over it. This was how it was going to be, and yet that made me feel worse.'*²⁷

Depression and anxiety can have an enormous detrimental impact on a woman. She may feel low, tearful, despondent and hopeless, tired and lethargic but unable to sleep, uninterested in doing anything, unable to concentrate, unable to eat, and hostile or indifferent to her partner or baby. She may feel unable to cope, may develop overwhelming anxiety about ordinary situations, may experience panic attacks and physical symptoms such as headaches and blurred vision, and may develop obsessive thoughts about the baby, about herself or other family members. A woman who experiences severe depression may have feelings of alienation and despair, and thoughts of self-harm and suicide.²⁸

*'I'm rubbish. I have nothing left...I hope I will make it. I don't know. I'm so confused. I'm lost... I pretend too much to be happy...I try to show people I am happy but inside me I am dead.'*²⁹

Living in a culture that simultaneously idealises and fails to support motherhood, a woman experiencing depression and anxiety may have feelings of inadequacy about her ability to adapt to her new responsibilities, and a sense of loss at the absence of happiness and fulfilment she had hoped for. She may feel angry that motherhood is so different from her expectations, and ashamed that she is unable to conform to the social norm of maternal contentment. She may feel guilty for having these feelings and even more guilty that she is failing her baby or even causing the baby developmental harm.^{10,6,28} She may perceive mental illness as a stigma and be unwilling to accept a label of depression, or on the other hand, she may find it a relief to have a name for her feelings.

Impact of depression and anxiety on children

Anxiety in pregnancy can have a lasting impact on the baby by impairing blood flow to the fetus and thereby affecting birthweight and future hypertension.³⁰ Untreated maternal depression can also have a lasting negative effect on children's social, emotional and cognitive development. The most immediate impact is that depression undermines a mother's ability to interact with her baby responsively, so that the baby is significantly less likely to form a secure attachment.³¹ Children (especially boys) of mothers who have been postnatally depressed are at increased risk of cognitive delay,^{32,33} and by the time they reach school have more behavioural problems (including violent behaviour) than children of non-depressed mothers.^{34,35} Moderate to severe depression in mothers and fathers increases their children's risk of experiencing depression themselves, particularly in early adulthood.³⁶

Impact of depression and anxiety on fathers

*'When she is low, I am low, I feel so helpless.'*³¹

*'(My son) was a beautiful, healthy baby and everybody kept telling me how proud I must be feeling. But I felt nothing but resentment. All I could think was, I'd made a terrible mistake...I had nobody to speak to; I didn't want to lose face with my mates, neither did I want to burden my wife, who was feeling low herself.'*³⁷

Mothers who are depressed tend to rely heavily on their partners for practical and emotional support,³⁸ but new fathers can find the experience of coping with their partner's depression overwhelming, frustrating, and isolating.³⁹ It is now recognised that new fathers are themselves also at increased risk of mental disorders.⁴⁰ Depression in both mothers and fathers is more likely if the couple relationship is not mutually supportive,⁴⁰ and in many families depression in one parent correlates with depression in the other, with up to half of men whose partners are depressed being affected by depression themselves.⁴¹ Group interventions appear to be positive in supporting some new fathers with these issues. An Australian randomised controlled trial of 268 new fathers found that low mood among new mothers with low self-esteem was significantly reduced by the fathers' participation in an antenatal session that focussed on the psycho-social aspects of the transition to parenthood, because the men had a greater understanding of how the mothers were feeling and were more willing to share household tasks.⁴² Another Australian study found that fathers who participated in a postnatal group for the partners of depressed women experienced lower levels of stress and depression themselves.³⁹

Causes and risk factors for depression

*'When the doctor told me I was pregnant I felt terrible. I cried for about three months. Because I was young, and I thought: I don't want this now.'*²⁹

The aetiology of antenatal and postnatal depression remains uncertain. In broad

ii Quote from Bounty discussion forum: www.bounty.com/community/discussion (accessed March 2007)

terms, there are two theoretical perspectives. The psycho-social models suggest that the causes are to be found primarily in a woman's difficulties in adapting to a new role and family structure, intensified by her circumstances or psychological history, including her own experiences of being parented. By contrast, the medical model points to genetic and biochemical explanations, including hormonal imbalance.

Depressed mothers themselves may prefer to conceptualise the origins of their feelings in different ways. For some women, a medical explanation may helpfully imply that what they are experiencing is 'not their fault' or not the result of what they fear is their own maladjustment to a normal experience; whereas for other women, a social or psychological account of their distress may appear to legitimise their feelings as part of a range of normal responses to the transition to parenthood, without implying that they are mentally ill.⁶ An international study of perspectives on postnatal depression found that across a variety of cultures, women described similar symptoms of morbid unhappiness as common after childbirth, and most identified psycho-social causes, including lack of social support, family conflict, tiredness and problems with the baby. Most European groups, but not people of Asian origin living in the UK, also mentioned hormones as a cause.⁴³

Although antenatal and postnatal depression can develop in women who have no identifiable risk factors, many women who develop depression are dealing with stressful psycho-social circumstances that undermine normal coping mechanisms. These include women who: have a history of depression, have a partner who is unsupportive or abusive, experience a general lack of social support, live in poverty, are very young, lost their own mothers as children, have a sick or premature baby, or are experiencing external stresses such as bereavement, moving house, losing a job or financial problems.^{28,44,45}

Prevention of depression and anxiety

Where a woman has symptoms of

depression and/or anxiety that are not serious enough for a formal diagnosis, but significantly interfere with social functioning, NICE recommends that targeted psycho-social interventions should be offered to prevent the symptoms from worsening. These should comprise brief psychological treatment for women who have a previous history of depression or anxiety, and social support (for example, regular informal individual or group-based support) for those with no previous history of anxiety or depression.³ However, NICE also recommends that psycho-social interventions aimed at preventing mental disorders should not be part of routine antenatal and postnatal care.³ NICE has found no evidence to support routine single-session debriefing after a traumatic birth, nor for routinely encouraging mothers to hold their baby after a stillbirth or early neonatal death.³

Identification of depression

*"It was a long time before I realized what I had was Post Natal Depression. I thought I just wasn't cut out to be a mother."*¹¹

Professionals' perspective on identification

The increased awareness that depression affects more than one in ten new mothers has prompted the development of screening tools that seek to predict depression before it develops and to identify it when present. The Edinburgh Postnatal Depression Scale (EPDS) is the most widely used screening tool in the UK, particularly by health visitors (community public health nurses). There has been considerable debate about the validity of screening tools, including their inappropriateness for use with women from minority ethnic cultures,¹⁷ their inability to predict future depression,⁴⁶ and the training that health professionals require to use them effectively.⁴⁷ Although the NHS in Scotland has been advised by the Scottish Intercollegiate Guidelines Network (SIGN) to use the EPDS as part of a screening programme,¹⁷ subsequently the National Screening Committee for the United Kingdom has recommended

that the EPDS should not be used as a screening tool, although it can be used as a checklist as part of a mood assessment alongside professional judgement and a clinical interview.⁴⁸

The latest guidance from NICE recommends a simple but systematic approach: at a woman's first contact with primary care, at her 'booking' visit and postnatally at 4-6 weeks and 3-4 months, primary healthcare professionals should ask all women two questions to identify possible depression:

(1) "During the past month, have you often been bothered by feeling down, depressed or hopeless?"

(2) "During the past month, have you often been bothered by having little interest or pleasure in doing things?"

If the answer to both questions is "yes," a third question should be asked:

(3) "Is this something you feel you need or want help with?"³

It must, however, be remembered that identification of clinical depression in the antenatal and postnatal period is complicated by the overlap between the symptoms of mild depression and the normal emotional changes associated with the transition to parenthood. These changes may mask the symptoms of depression, or alternatively be misidentified as depression.¹⁷

Women's perspectives on identification

*'I didn't want to admit to anyone just how inadequate, lonely and depressed I was feeling. I thought it made me seem a failure as a mother, and I also felt guilty for feeling so bad when I had two perfectly healthy children, when so many others are in a worse situation.'*ⁱⁱⁱ

It is widely acknowledged that many women experiencing depression do not seek, or actively avoid, a diagnosis. Some women deliberately conceal their true mood while being screened for depression, because of feelings of shame at 'not coping,' reluctance to discuss intimate feelings with a relative

iii Quote from Netmums. Finding mums with postnatal depression. http://www.netmums.com/lc/pndscreening_survey.php#results (accessed March 2007)

stranger, a belief that no useful help would be forthcoming, or fear of the consequences of diagnosis (e.g. attracting the involvement of Social Care services with their children, or having to declare the diagnosis when applying for a future job).⁶ ⁱⁱⁱ An online survey of mothers found that nearly half of women who felt they were unwell had not told their health visitor the truth when screened using the EPDS.ⁱⁱⁱ

In other cases, women may not understand what is happening to them or from whom to seek help.¹⁰ In addition, women living in very marginal circumstances, who may be at disproportionate risk of depression (e.g. homeless women, asylum seekers), may not be sufficiently in contact with primary health services to have their mental health needs identified.⁴⁹

Mental disorders are expressed differently in different cultures. For example, in some cultures depression is not acknowledged as an illness, or it may be conceptualised as a moral or spiritual issue, not a medical one, and a term such as 'depression' may not be recognised.^{43,50,51} Many women somatise psychological distress (i.e. express their psychological state as physical symptoms) and some research suggests that this is particularly likely for women from some minority ethnic communities.^{iv} ⁵⁰ Mental illness in some communities carries the exclusive connotation of 'going mad' and is associated with enormous stigma both for the individual and her family, so there is an emphasis on concealment.^{51,52} Black and minority ethnic women are generally more vulnerable to misdiagnosis of mental illness, which has been attributed to cultural differences in presentation, the cultural relativism of Western psychiatric categories, racial stereotyping by health professionals and language differences.⁵³ Efforts are being made to address some of these issues. For example, the Community Practitioners and Health Visitors Association has developed a series of picture-based booklets in minority community languages which have been found to be effective in enabling women to talk to their health visitor about their feelings.⁵⁴

Treatment options for depression and anxiety

*'I cry all the time. I can't cope any more. I don't know who I need to ask for help.'*²⁹

The divide between the psycho-social and medical models of understanding depression is reflected in the range of treatments available. The influence of the medical model within the NHS is significant, reflected in the current high use of pharmacological treatments. However, there is a growing body of evidence to support the use of psychological therapies which are a response to the psycho-social theories about the causes of mental disorder. These therapies include Cognitive Behavioural Therapy (CBT), counselling, psychotherapy, 'listening visits' (non-directive counselling) from trained health professionals (usually health visitors), and facilitated groups. All of these treatments have been positively evaluated as effective in helping women to recover from mild to moderate depression, and CBT has been found to be effective in addressing anxiety.³

In practice, most women have a limited choice of treatment. At present, drug therapy is generally the NHS's first choice in the treatment of mental disorder on the grounds of cost and availability of services. A recent survey by mental health charity MIND found that 75% of women with antenatal and postnatal mental disorders were offered medication, whereas fewer than two in five were offered counselling and fewer than one in five were offered CBT.¹⁰ Women from Black and minority ethnic communities are historically more likely than White women to be offered drug treatments instead of psychological treatments for depression.

The recent NICE guidance on antenatal and postnatal mental health recommends a transformation of this approach. Because of the potential risks from psychotropic medication (including antidepressants) during pregnancy and breastfeeding, the thresholds for non-drug treatments are lower in the antenatal and postnatal period than at other times. Therefore NICE recommends that for

mild to moderate depression, health professionals should first consider self-help strategies, 'listening visits', and brief CBT or interpersonal therapy. Antidepressant drugs should only be considered if the woman has a history of severe antenatal or postnatal depression and her mild symptoms worsen or do not improve, or if she has moderate symptoms and a history of depression and has expressed an informed preference for antidepressant treatment. For severe depression, NICE recommends structured psychological treatment specifically for depression (CBT or interpersonal therapy), antidepressant treatment if the woman has expressed an informed preference for it, and combination treatment if there is a limited response. NICE further recommends that all psychological treatments should normally be started within one month of assessment, and no later than three months.³

Women who do not receive treatment

Although access to psychological therapies for all who need it will be an important step forward, not all women seek professional help for their depression and anxiety.

Some women make a specific decision to cope alone, as discussed above. Women in difficult socio-economic circumstances may prioritise accessing help with resolving crisis issues such as housing or immigration status over their own mental health needs.^{50,49} Some women reject the concept of counselling as intrusive and untrustworthy, and it is not usually available to women who do not speak English.^{51,29} Women experiencing depression who do not have any treatment will usually recover spontaneously, but this is a gradual process that may take many months or longer.⁵⁵

Informal treatment

'I was a bit depressed at first, and that just helped me get through, having new friends. I broke up from school and all my friends went on and did their own little thing, and I just found loads of new friends (at the group)...'^v

As noted above, NICE recommends self-help strategies, including 'guided

iv Wessely S. The somatisation of depression. Royal Society of Medicine Lecture, 29th October 1999

self-help' (written information or an internet programme about depression and what you can do to feel better, such as eating well, steps to improve sleep, and prioritising enjoyable activities), computerised CBT and taking exercise, as part of a first line of treatment for mild to moderate depression. The Royal College of Psychiatrists emphasises the importance for women of talking about their feelings and seeking support with practical tasks from family and friends, to get time to catch up on sleep and have time away from the demands of caring for their baby and home.⁵⁵

Some women experiencing depression benefit from using 'alternative' or complementary therapies. For example, a pilot study of depressed mothers found that those who attended infant massage classes had an improved relationship with their babies.⁵⁶ An Australian study of women with postnatal depression found that many preferred to start a 'special diet' or to use St John's Wort to help them cope with depression, rather than taking anti-depressant medication.^v

Where social isolation is a factor in low mood, both structured and unstructured groups may enable women to build friendships and new social networks to replace relationships that have dwindled because of parenthood or other life changes such as moving to a new area. Some women feel that groups provide them with essential space to relax, get a break from the seemingly unremitting demands of childcare and spend time on themselves as well as talking about their feelings.^{10,57} However, where a group is time-limited, the positive impact on social networks is not necessarily maintained once it has finished,⁵⁸ and not all women want to make use of groups.¹⁰ Some women with access to the internet derive considerable mutual support from the online communities of women experiencing antenatal and postnatal depression and anxiety.^{vii}

Information needs

Mothers with mental health problems surveyed by MIND overwhelming rated infor-

mation about how to recognise the signs and symptoms of mental health problems as the most useful information they had received during pregnancy, followed by information about the common emotional changes after childbirth and how and when to get in touch with services.

Summary

Historically there has been a tendency to overlook antenatal mental disorders and to blur together all postnatal symptoms under the label of "postnatal depression". This focus has been reflected in research and has resulted in an evidence base heavily biased towards postnatal depression to the exclusion of other mental disorders, although this has been addressed in the recent NICE guidance on antenatal and postnatal mental health.

Having a baby may trigger a further episode of serious mental illness for women with a history of severe mental health problems, so care givers should ask pregnant women and new mothers about their psychiatric history. Where a woman is identified as being at high risk of serious mental illness, a care plan should be drawn up in early pregnancy. Where serious mental illness does occur, a woman requiring in-patient care should have access to a Specialist Mother and Baby Psychiatric Unit in order to avoid separation from her baby.

Broadly speaking, there are two theoretical perspectives on depression: the medical model points to genetic and biochemical explanations, and suggests pharmacological treatment, while the psycho-social models point to causes rooted in the woman's circumstances, psychological history and her adaptation to motherhood, and suggest psychological therapies. These approaches are not mutually exclusive as there may be multiple and inter-relating physiological and psycho-social factors affecting a woman's mental health. NHS practitioners may work with 'biopsychosocial' perspective - acknowledging the relative contributions to aetiology and intervention rather than taking an 'either/or' approach. Because of the risks associated with psychotropic

medication during pregnancy and breastfeeding, NICE recommends that self-help strategies and psychological therapies should be used to treat mild to moderate depression in the first instance, with antidepressants only to be used if a woman has moderate to severe depression and has expressed an informed preference for drug treatment, or her symptoms do not respond to psychological therapy.

Untreated antenatal and postnatal depression and anxiety can have serious detrimental effects on the woman, her baby and her partner, who may also experience postnatal depression. NICE recommends that all women should be routinely questioned about their mood during antenatal and postnatal care to identify possible depression. However, some women may not seek or may actively avoid diagnosis. Diagnosis is complicated by the overlap between some of the symptoms of depression and the normal emotional changes associated with the transition to parenthood.

Key points

- Women may experience a range of mental health problems during and after pregnancy.
- Women are at increased risk of experiencing depression if they have a history of depression, have a partner who is unsupportive or abusive, experience a general lack of social support, live in poverty, are very young, lost their own mothers as children, have a sick or premature baby, or are experiencing external stresses such as bereavement, moving house, losing a job or financial problems.
- Anxiety in pregnancy can affect babies' birth weight and future risk of hypertension. Untreated maternal depression can have a lasting negative effect on children's social, emotional and cognitive development.
- New fathers are at increased risk of mental disorders, with depression for both partners being more likely if the couple relationship is not mutually supportive. Up to half of men whose partners are depressed are

v Quote from woman interviewed by author for the National Evaluation of Sure Start qualitative evaluation of maternity services in Sure Start local programmes beyondblue. Postnatal Depression Research Program Report Volume 1. Hawthorn West: beyondblue 2006. <http://www.beyondblue.org.au/> (accessed March 2007)

vii For example, the message boards of Perinatal Illness UK: www.pni-uk.com

depressed themselves.

- All women should be asked about their psychiatric history and their current mood as a routine part of antenatal and postnatal care.
- Antidepressants should be prescribed cautiously during pregnancy and breastfeeding, and only after discussion of the risks. Psycho-social treatments should be the first line of treatment wherever appropriate.
- Self-help strategies, practical and emotional support from friends and family, and opportunities to get involved with social networks of new parents (face to face and by email) can help to prevent or reduce mild to moderate depression.

Further information

- MIND (National Association for Mental Health): 0845 766 0163, www.mind.org.uk
- SANE: 0845 767 8000, www.sane.org.uk
- Perinatal Illness UK: www.pni-uk.com/
- Association for Post-Natal Illness: 020 7368 0868, www.apni.org

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