Perinatal depression and anxiety

A guide for primary care health professionals

Adjusting to pregnancy and life as a mother can have its challenges. In fact, for many women, having a baby is the most significant life-changing event they will ever experience. While adjusting to this major life change, as well as coping with the day-to-day demands of pregnancy or a new baby, some women are more likely to experience depression and/or anxiety, particularly if they've experienced a mental health problem in the past.

WHAT IS PERINATAL DEPRESSION AND ANXIETY?

'Perinatal' is the collective term used to describe both *antenatal* and *postnatal* depression and anxiety. *Antenatal* depression and anxiety is experienced during pregnancy and *postnatal* depression and anxiety is experienced within the first year after the baby's birth.

HOW COMMON IS PERINATAL DEPRESSION AND ANXIETY?

- Australian research indicates that up to one in 10 women will experience depression during pregnancy. This rate of depression increases to around one in seven women in the year following the birth of their baby.
- The information available on perinatal anxiety disorders indicates that anxiety is likely to be at least as common as depression (if not more) during this time. It is also common for women to experience symptoms of depression as well as anxiety, however severe anxiety can also be present without depression.

WHAT CAUSES PERINATAL DEPRESSION AND ANXIETY?

As with depression and anxiety disorders that occur at any other time during a woman's life, there is no single, definite cause. A combination of factors is known to increase a woman's chances of experiencing depression and/or anxiety during the perinatal period. These factors may be identified by undertaking a psychosocial assessment. (For more information see the *beyondblue* booklet *Psychosocial assessment in the perinatal period: A guide for primary care health professionals.*)

These factors include:

- past or present mental health problems
- previous or current abuse (sexual, physical or psychological)
- previous or current drug and/or alcohol abuse
- recent life stressors (e.g. moving house, financial worries, relationship problems, IVF, multiple birth)
- lack of practical and emotional support
- poor (insecure) attachment with a woman's own mother.

For some women, other factors that might play a role are:

- experiencing severe 'baby blues'
- complications during labour and/or delivery
- multiple births and/or problems with the baby's health
- difficulty breastfeeding
- difficulties in close/family relationships
- single parenthood
- an unsettled baby (difficulty with feeding or sleeping)
- unrealistic expectations about motherhood
- being a 'perfectionist'.

The Perinatal Clinical Practice Guidelines[1] which inform this publication are more than 5 years old and currently under review. The information in this publication may no longer reflect current evidence or best practice. While the information may still be useful and/or relevant, *beyondblue* gives no assurance to the accuracy or relevance of the information contained and strongly suggests that clinicians and health professionals always check for and be up to date with the latest research.

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[1] *beyondblue* (2011) *Clinical practice guidelines for depression and related disorders – anxiety, bipolar disorder and puerperal psychosis – in the perinatal period. A guideline for primary care health professionals.* Melbourne: *beyondblue*

HOW DO YOU KNOW IF A WOMAN HAS PERINATAL DEPRESSION AND/OR ANXIETY?

Depression and anxiety experienced during pregnancy and after birth have the same symptoms as depression and anxiety experienced at any other time of life.

The Edinburgh Postnatal Depression Scale (EPDS)[1] is a set of questions designed to detect the likelihood of depression and anxiety in women during the perinatal period. The EPDS deliberately excludes the problems experienced by most women in the perinatal period (e.g. tiredness, sleep disturbance, irritability). **The EPDS is a screening tool and does not provide a diagnosis.** The woman's answers to the questions will indicate if she has symptoms that are commonly found in women with perinatal depression and anxiety.

To complete this set of questions, a woman should circle the number next to the response that comes closest to how she has felt in the **PAST SEVEN DAYS**. If the woman has difficulty reading or understanding the questions, it may be more appropriate to go through the questions with her.

Here is a completed example.

I have felt happy	
Yes, all the time	0
Yes, most of the time	(1)
No, not very often	2
No, not at all	3

This would mean:

"I have felt happy most of the time during the past week".

Please complete the other questions in the same way.

1.	**I have been able to laugh and see the funny side of things**	
	As much as I always could	0
	Not quite so much now	1
	Definitely not so much now	2
	Not at all	3
2.	**I have looked forward with enjoyment to things**	
	As much as I ever did	0
	Rather less than I used to	1
	Definitely less than I used to	2
	Hardly at all	3
3.	**I have blamed myself unnecessarily when things went wrong**	
	Yes, most of the time	3
	Yes, some of the time	2
	Not very often	1
	No, never	0
4.	**I have been anxious or worried for no good reason**	
	No, not at all	0
	Hardly ever	1
	Yes, sometimes	2
	Yes, very often	3
5.	**I have felt scared or panicky for no very good reason**	
	Yes, quite a lot	3
	Yes, sometimes	2
	No, not much	1
	No, not at all	0
6.	**Things have been getting on top of me**	
	Yes, most of the time I haven't been able to cope at all	3
	Yes, sometimes I haven't been coping as well as usual	2
	No, most of the time I have coped quite well	1
	No, I have been coping as well as ever	0
7.	**I have been so unhappy that I have had difficulty sleeping**	
	Yes, most of the time	3
	Yes, sometimes	2
	Not very often	1
	No, not at all	0
8.	**I have felt sad or miserable**	
	Yes, most of the time	3
	Yes, quite often	2
	Not very often	1
	No, not at all	0
9.	**I have been so unhappy that I have been crying**	
	Yes, most of the time	3
	Yes, quite often	2
	Only occasionally	1
	No, never	0
10.	**The thought of harming myself has occurred to me**	
	Yes, quite often	3
	Sometimes	2
	Hardly ever	1
	Never	0

The total score is calculated by adding the numbers circled for each of the 10 questions. The higher the score, the more likely it is that the woman completing the questionnaire is distressed and may be depressed and/or anxious.

INTERPRETING AND RESPONDING TO EPDS SCORES

Low risk	Possible risk	Possible high risk
Total EPDS score (symptoms of depression)		
Score 10, 11, 12	13 or more	15 or more
• Arrange repeat EPDS in 2–4 weeks. • Review existing supports.	• Antenatal: arrange repeat EPDS in 2–4 weeks. • Postnatal: refer for mental health assessment.* • Discuss referral.*	• Ensure timely access to mental health assessment.
Score on Question 10 (self-harm)		
0	1, 2 or 3	
• Care as usual.	• Assess safety of woman, fetus or infant and other children in her care. • Seek timely advice and/or refer for mental health assessment.	
Scores on Questions 3, 4 and 5 (anxiety)		
0	0 & yes to psychosocial risk question on worry.	1, 2 or 3 on more than one item ± yes to psychosocial risk question on worry.
• Care as usual.	• Note in woman's record. • Offer information on self help.	• Arrange repeat EPDS in 2–4 weeks. • Discuss referral for assessment.*
Risk of suicide (Question 10 on EPDS)		
Low risk	Possible risk	Possible high risk
Passing thoughts of self-harm or suicide but no plan or means	**Suicidal thoughts and intent but no plan or immediate means**	**Continual/specific suicidal thoughts, intent, plan and means**
• Discuss support and treatment. • Arrange follow-up.	• Discuss support and treatment. • Develop safety plan with the woman including rapid re-assessment if symptoms escalate. • Provide support/crisis numbers. • Arrange re-assessment within 1 week.	• Ensure woman is in a safe and secure environment with social/professional supports. • Arrange re-assessment within 24 hours. • Provide crisis contact numbers. • Assess risk to infant. • Contact appropriate crisis support. • Consider hospital admission.

Notes: * Ideally, referral will be to the woman's usual general practitioner (GP), local groups focusing on parenting or specific services (e.g. domestic violence).

HOW ARE PERINATAL DEPRESSION AND ANXIETY TREATED?

Psychological therapies

Cognitive behavioural therapy (CBT), interpersonal psychotherapy (IPT) and psychodynamic therapy have been shown to improve depression and anxiety symptoms in the postnatal period. The choice of therapy involves consideration of psychological and physical comorbidities, barriers to help-seeking and the likely impact on the woman, infant and family of not treating the condition. Discuss the suitability and acceptability of therapies with the woman and her significant other(s) to assist in making an informed decision.

For women with moderate to severe symptoms, pharmacological treatment needs to be considered initially. Psychological interventions can be introduced once the more severe symptoms have resolved and the woman is able to engage in therapy.

Psychotherapy involving the mother and the infant may improve mother–infant interaction. The mother and infant are seen together and the therapy focuses on the mother-infant relationship and maternal sensitivity.

Psychological therapies should be provided by registered practitioners with accredited training in the relevant therapy.

Medication

Medication can play an important role in helping people with depression and/or anxiety manage from day to day.

Medication should only be prescribed after careful deliberation with the woman and her significant other(s) when she is planning a pregnancy, is pregnant or breastfeeding.

When symptoms are severe involving a psychiatrist is advisable.

Depression

Based on the quantity of evidence available, the preferred antidepressants are selective serotonin reuptake inhibitors (SSRIs). Less is known about the safety of tricyclic antidepressants (TCAs) but they can also be considered, especially if they have been effective previously.

Anxiety

Benzodiazepines can be used to treat panic attacks and severe anxiety disorder in the short-term while awaiting the onset of action of an SSRI or TCA. Long-acting benzodiazepines should be avoided.

While there are risks associated with using medications in the perinatal period, it should not be assumed that it is always better to avoid medication. The decision to take medication is up to the individual and should be made after considering the risks and benefits to both the mother and the infant.

For more information, see the *beyondblue* booklet *Management of perinatal mental health disorders: A guide for primary care health professionals.*

HOW TO HELP A WOMAN WITH PERINATAL DEPRESSION AND ANXIETY

- Remind the woman that **these conditions can be treated and managed**.
- Provide the woman with information about perinatal depression and anxiety.
- Encourage the woman to consult and keep regular appointments with her general practitioner (GP) or other qualified health professional.
- Encourage the woman to draw on her support networks for time out and assistance with housework, like cooking and cleaning.
- Encourage the woman to seek friendships with other women, including those who have experienced perinatal depression and/or anxiety. Let the woman know how well she is doing when she makes small gains.
- Encourage the woman to use some self-help strategies as outlined in the beyond babyblues booklets designed for expectant and new parents.
- Encourage the woman to call a support service or mental health crisis line if she is feeling distressed and/or needs support.
- Encourage the woman to contact her doctor or go to her local hospital if she has thoughts of self harm or harming others.
- Offer information and support for the woman's partner.

INFORMATION RESOURCES FOR WOMEN AND THEIR FAMILIES

The beyondblue guide to emotional health and wellbeing during pregnancy and early parenthood

Managing mental health conditions during pregnancy and early parenthood: A guide for women and their families

INFORMATION AND HELP LINES

For women and their families

beyondblue
1300 22 4636
www.beyondblue.org.au

PANDA – Perinatal Anxiety and Depression Australia
1300 726 306
www.panda.org.au

For health professionals

beyondblue
1300 22 4636
www.beyondblue.org.au

Parent-Infant Research Institute (PIRI)
www.piri.org.au

TGA electronic Therapeutic Guidelines and Medications Handbook
https://tgldcdp.tg.org.au/etgcomplete

Black Dog Institute
www.blackdoginstitute.org.au

REFERENCES

[1] Cox JL, Holden JM, Sagovsky R (1987) Detection of postnatal depression: development of the 10-item Edinburgh postnatal depression scale. *Brit J Psychiatry* 150: 782-86. Developed as the Edinburgh Postnatal Depression Scale and validated for use in both pregnancy and the postnatal period to assess for possible depression and anxiety.

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