Perinatal Depression

A guide for health professionals

The term 'perinatal depression' refers to depression experienced at any time in the antenatal period or in the 12 months following the birth of a baby (postnatal period). Perinatal depression is common. However, it is often missed or misattributed to aspects of pregnancy (e.g. hormones) or having a baby (e.g. adjustment, sleep deprivation). Being aware of symptoms, referral pathways and effective treatments is critical for health professionals caring for women in the perinatal period.

Prevalence

Australian research indicates that:

- Up to 1 in 10 women experience depression in pregnancy
- Around 1 in 7 experience depression in the year following birth.

It is also common for women to experience depression and anxiety concurrently.

Causes

There is no single, definite cause of depression – rather it is likely to result from a combination of biological (e.g. personal/family history of depression), psychological (e.g. coping strategies, cognitive style) and social factors (e.g. access to support).

The combination of these risk factors may place a woman at increased risk of developing depression in the perinatal period. These risk factors are reflected in recommended psychosocial assessment scales/questions.

Symptoms

- A woman experiencing perinatal depression is likely to experience a loss of interest or pleasure in her everyday life together with a range of other physical (e.g. lethargy, numbness), cognitive (e.g. negative thinking), behavioral (e.g. withdrawal) and/or emotional symptoms (e.g. tearfulness).
- Like depression experienced at other times of life, depression in the perinatal period is identified by the presence of a number of symptoms experienced over a period of time – typically 2 weeks or more.
- Depression affects the ability of the woman to function to her normal capacity from day to day. Moderate to severe perinatal depression can also affect a mother's ability to care for her baby and/or other children in her care.

Screening and assessment

Edinburgh Postnatal Depression Scale

The Edinburgh Postnatal Depression Scale (EPDS) is a screening tool specifically designed to identify possible depression in the perinatal period. Comprising 10 questions, the screening tool asks the woman to choose from one of four responses that best describe how she has been feeling in the past 7 days.

All women should be offered the EPDS at least four times in the perinatal period – as early as practical in pregnancy, once later in pregnancy, 6–12 weeks after the birth and again in the first postnatal year.

Appropriate responses to EPDS scores are:

10 to 12 – offer repeat EPDS as the woman may go on to develop a depressive disorder

13 or more — offer further assessment as the woman may have major depression

Positive score on Question 10 — offer further assessment as the woman is at risk of harming herself and/or her children.

When screening Aboriginal and Torres Strait Islander women or migrant and refugee women, language and cultural appropriateness of the tool are considerations.

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Antenatal Risk Questionnaire

The Antenatal Risk Questionnaire (ANRQ) addresses key domains of psychosocial health that have been shown to be associated with increased risk of perinatal mental health morbidity (e.g. depressive or anxiety disorder) and less optimal mother-infant attachment.

The ANRQ can be self-completed or administered by the health professional and can be used during pregnancy or postnatally. The ANRQ has 12 scored items relating to the following risk domains:

- mental health history
- history of physical, sexual or emotional abuse or neglect
- level of practical support and emotional support from partner
- anxiety and perfectionism levels
- stressors/losses in the last year (e.g. bereavement, separation etc.).

The ANRQ should only be used by appropriately trained staff with ongoing clinical supervision and, should be administered with a depression screening measure (e.g. EPDS), ideally towards the end of a visit. ANRQ responses should be discussed with the woman and a psychosocial care plan developed as appropriate.

The EPDS and ANRQ are screening tools only and further mental health assessment by a qualified health professional is required to provide a diagnosis.

Treatment and management

As with depression at other times of life, psychological and medical treatments are the basis of treatment and management in the perinatal period.

Psychological therapies

Psychological therapies are recommended for *mild to moderate* perinatal depression.

Psychological therapies target thoughts, feelings and behaviours and include cognitive-behavioural therapy (CBT), interpersonal therapy (IPT), and psycho-dynamic therapy. Psychotherapy involving the infant may improve mother-infant interaction and provide an opportunity to focus on the mother-infant relationship and maternal sensitivity.

The choice of therapy involves consideration of the woman's preferences, the severity of her depression, other psychological and physical conditions and her access to treatment.

Psychological therapies should only be provided by registered health professionals with accredited training and experience.

Medication

If depressive symptoms are *moderate to severe*, pharmacological treatment (medication) needs to be considered initially. Psychological therapy may be introduced once the symptoms have resolved and the woman is able to engage in therapy.

The preferred antidepressants for use in the perinatal period are **selective serotonin reuptake inhibitors** (SSRIs), which can also be used for anxiety. Tricyclic antidepressants (TCAs) can also be considered, especially if they have been effective previously.

Antidepressants should only be prescribed after careful deliberation with the woman and her significant others when she is planning a pregnancy, is pregnant or breastfeeding. If depression symptoms are severe, involving a psychiatrist is advisable.

Electroconvulsive therapy (ECT)

ECT may need to be considered in cases of severe or psychotic depression, particularly if the woman is not responding to medication.

Tips for providing support

Listen and reassure

- Encourage the woman to discuss any symptoms she may be experiencing.
- Assure the woman that perinatal depression can be treated and managed.

Provide information

- Refer all women to Ready to COPE – to receive ongoing information and support strategies throughout her pregnancy and /or the postnatal period.
- Provide the woman with quality information about perinatal depression – see COPE consumer fact sheet.
- Provide details of helplines if she is feeling distressed and needs support.
- Offer information to the woman's partner/others.

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A guide for health professionals

Direct to care and support

- Encourage the woman to consult with her general practitioner (GP) or other qualified health professional.
- Encourage the woman to identify and draw on possible supports and services that may be available to her for practical and/or emotional support.
- Remind the woman that she can go to her doctor or local hospital if she is at risk of harming herself or others.

Information for women and their families:

Ready to Cope Guide:

Women can receive free fortnightly information about emotional and mental health throughout the perinatal period at **readytocope.org.au**

Information:

Provide women with fact sheet on depression in **pregnancy** and the **postnatal** period.

Telephone support:

To access peer support person or health professional call the **PANDA helpline** on 1300 726 306 (Monday to Friday 9.00am – 7.30pm AEST/AEDT).

Further mental health information:

To find out about other mental health organisations and services visit **headtohealth.gov.au**

Further information for health professionals:

- Edinburgh Postnatal Depression Scale (EPDS)
- Antenatal Risk Questionnaire (ANRQ)

Centre of Perinatal Excellence

This fact sheet has been developed by COPE: Centre of Perinatal Excellence and is derived from *Mental Health Care in the Perinatal Period: Australian Clinical Practice Guideline*. 2017. Centre of Perinatal Excellence.

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