Clinical Guideline
Perinatal Anxiety and Depressive Disorders (including Postnatal Depression)

Policy developed by: SA Maternal, Neonatal & Gynaecology Community of Practice
Approved SA Health Safety & Quality Strategic Governance Committee on: 01 March 2017
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Summary
The Perinatal Anxiety and Depressive Disorders (including Postnatal Depression) Perinatal Practice Guideline provides clinicians with information on prevention, diagnosis and interventions for women at risk of or experiencing depression and/or anxiety in the perinatal period.

Keywords
perinatal anxiety and depressive disorders, PPG, perinatal practice guideline, anxiety, depression, perinatal depression, mood swings, EPDS, Edinburgh Postnatal Depression Scale, psychosocial questionnaire, antenatal risk questionnaire, ANRQ, screening for perinatal anxiety and depression, clinical guideline, postnatal depression, PND

Policy history
Is this a new policy? N
Does this policy amend or update an existing policy? Y v2.0
Does this policy replace an existing policy? N
If so, which policies?

Applies to All Health Networks
CALHN, SALHN, NALHN, CHSALHN, WCHN, SAAS

Staff impact All Staff, Management, Admin, Students, All Clinical, Medical, Midwifery, Nursing, Allied Health, Emergency, Mental Health

PDS reference CG248

Version control and change history

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<th>Version</th>
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South Australian Perinatal Practice Guidelines

Perinatal Anxiety and Depressive Disorders (including Postnatal Depression)

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Note

This guideline provides advice of a general nature. This statewide guideline has been prepared to promote and facilitate standardisation and consistency of practice, using a multidisciplinary approach. The guideline is based on a review of published evidence and expert opinion.

Information in this statewide guideline is current at the time of publication.

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Health practitioners in the South Australian public health sector are expected to review specific details of each patient and professionally assess the applicability of the relevant guideline to that clinical situation.

If for good clinical reasons, a decision is made to depart from the guideline, the responsible clinician must document in the patient’s medical record, the decision made, by whom, and detailed reasons for the departure from the guideline.

This statewide guideline does not address all the elements of clinical practice and assumes that the individual clinicians are responsible for discussing care with consumers in an environment that is culturally appropriate and which enables respectful confidential discussion. This includes:

- The use of interpreter services where necessary,
- Advising consumers of their choice and ensuring informed consent is obtained,
- Providing care within scope of practice, meeting all legislative requirements and maintaining standards of professional conduct, and
- Documenting all care in accordance with mandatory and local requirements

Explanation of the Aboriginal artwork:
The Aboriginal artwork used symbolises the connection to country and the circle shape shows the strong relationships amongst families and the Aboriginal culture. The horse shoe shape design shown in front of the generic statement symbolises a woman and those enclosing a smaller horse shoe shape depicts a pregnant women. The smaller horse shoe shape in this instance represents the unborn child. The artwork shown before the specific statements within the document symbolises a footprint and demonstrates the need to move forward together in union.

Australian Aboriginal Culture is the oldest living culture in the world yet Aboriginal people continue to experience the poorest health outcomes when compared to non-Aboriginal Australians. In South Australia, Aboriginal women are 2-5 times more likely to die in childbirth and their babies are 2-3 times more likely to be of low birth weight. The accumulative effects of stress, low socio economic status, exposure to violence, historical trauma, culturally unsafe and discriminatory health services and health systems are all major contributors to the disparities in Aboriginal maternal and birthing outcomes. Despite these unacceptable statistics the birth of an Aboriginal baby is a celebration of life and an important cultural event bringing family together in celebration, obligation and responsibility. The diversity between Aboriginal cultures, language and practices differ greatly and so it is imperative that perinatal services prepare to respectively manage Aboriginal protocol and provide a culturally positive health care experience for Aboriginal people to ensure the best maternal, neonatal and child health outcomes.

Purpose and Scope of PPG

The purpose of this guideline is to give clinicians information on prevention, diagnosis and interventions for women at risk of or experiencing depression and/or anxiety in the perinatal period.
Summary of Practice Recommendations

> Approximately 1 in 5 women will experience anxiety and/or depression in the perinatal period
> Maternal suicide is a common cause of maternal death in Australia
> Early diagnosis through screening and follow up managed by a health professional improves the mental health outcomes of women
> Urgent specialised mental health referral is imperative when women express suicidal or infanticidal ideation
> Perinatal depression and/or anxiety can impact child development and functioning with ongoing effects into adolescence

Abbreviations

<table>
<thead>
<tr>
<th>CFH</th>
<th>Child and Family Health</th>
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<tr>
<td>EPDS</td>
<td>Edinburgh (postnatal) depression scale</td>
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<td>e.g.</td>
<td>For example</td>
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<td>et al.</td>
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<tr>
<td>GP</td>
<td>General Practitioner</td>
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<td>KEMH</td>
<td>King Edward Memorial Hospital</td>
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<td>PND</td>
<td>Postnatal depression</td>
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Introduction

> Anxiety and depressive disorders are common in the perinatal period (conception to 12 months post-natal), occurring in 1 in 5 women
> Women are more likely to develop a mental health disorder during this time of life than any other¹
> Depression and anxiety may occur together², are often present antenatally and persist if not treated. These disorders can have a wide range of effects for the fetus³, the infant, partner and family⁴
> Antenatal anxiety is associated with preterm birth, low birth weight and other obstetric complications⁵
> Perinatal depression and anxiety may be associated with poorer cognitive⁶ and behavioural functioning in children⁷, emotional problems⁸, reduced attention span, childhood anxiety⁹, and mother-infant attachment disorders¹⁰. Risks of depression for children can continue into adolescence¹¹
> Maternal death through suicide can be a result of severe mood disorder and ranks equal to obstetric haemorrhage as cause of maternal death in Australia¹².
> Suicide is a major cause of maternal death in high income countries¹³
> 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. This treatment of the mother alone may not be adequate to assuage the effect on the children⁴ (see “assessing parent infant relationship” PPG in the A-Z index www.sahealth.sa.gov.au/perinatal)
Risk factors
Where risks are identified, document details about the nature and degree of risk

Psychological
- Antenatal anxiety, depression or mood swings\textsuperscript{14,15}
- Previous history of anxiety, depression, or mood swings\textsuperscript{14,15}, especially if occurred perinatally
- Family history of anxiety, especially in first degree relatives\textsuperscript{15,16}
- Alcohol abuse\textsuperscript{17}
- Personal characteristics of being guilt-prone, perfectionistic, feeling unable to achieve, low self-esteem\textsuperscript{18}
- Edinburgh postnatal depression score $\geq 13$
- Borderline Personality Disorder

Social
- Lack of emotional and practical support from partner and / or others\textsuperscript{14,15}
- Domestic violence, history of trauma or abuse (including childhood sexual abuse)\textsuperscript{16}
- Many stressful life events recently\textsuperscript{14,15}
- Low socioeconomic status, unemployment\textsuperscript{14,15}
- Unplanned or unwanted pregnancy\textsuperscript{14,15}
- Increased parity

Aboriginal women may experience feelings of disconnectedness from family and country and may need to talk to the nominated aboriginal health professional

Biological / medical
- Ceased psychotropic medications recently
- History of serious pregnancy or birth complications (current or previous), neonatal loss, poor physical health, chronic pain or disability\textsuperscript{17}, or premenstrual syndrome\textsuperscript{19}
- Perinatal sleep deprivation
- Multiple pregnancy\textsuperscript{20}
- Chronic/medical illness\textsuperscript{17}
- Preterm birth/low birth weight\textsuperscript{21} - as a complication in the current pregnancy is a risk for postnatal depression and anxiety
- Neonatal medical problems or difficult temperament\textsuperscript{22}
Diagnosis

Major depressive disorder criteria:
Note: Symptoms must be present and persistent for at least two weeks\(^{23}\)

- 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)

Other relevant factors in severe depression postpartum

- Mothers may also report obsessive thoughts or images about harming themselves or their infant. Guilt and shame can prevent them talking to family or professionals and thereby receiving help
- See ‘Psychosis in pregnancy and postpartum’ in the A to Z index at www.sahealth.sa.gov.au/perinatal

Borderline Personality Disorder

- For further information, see ‘Personality disorders and pregnancy’ in the A to Z index at www.sahealth.sa.gov.au/perinatal
- Women with a diagnosis of BPD may have many complex traumas in their past including verbal, physical & sexual abuse
- Women with this personality style\(^{24,25}\) may also become depressed but on a background of chronic mood instability (particularly anger), impulsivity, interpersonal difficulties and deliberate self harm\(^{26}\)
- These mothers often have difficulties managing their infants particularly with soothing and settling; they may become very anxious and overwhelmed easily with caretaking tasks\(^{27}\). They are perhaps more likely to harm their infant than other women. Infants are at risk of dysregulated behaviour\(^{28}\)

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 cortisol\(^{29}\). Thus recognition and active treatment is entirely appropriate (See ‘screening for perinatal anxiety and depression’ in the A to Z index at www.sahealth.sa.gov.au/perinatal)
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
> For further information see ‘substance use in pregnancy’ in the A to Z index at www.sahealth.sa.gov.au/perinatal

Aboriginal women should be referred to an aboriginal health professional as soon as practicable to support their care

Anxiety Disorders

> 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
> Fear and phobias may emerge for the first time or be magnified by the normal stressors of pregnancy and childbirth
> Tokophobia (a fear of giving birth), may cause some women to want to terminate the pregnancy or ask for a caesarean section in attempt to control their fear
> 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 agoraphobic and socially isolated
> Women are at higher risk of Obsessive Compulsive Disorder in pregnancy and postpartum
> Obsessive Compulsive Disorder may be extremely debilitating postpartum 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 postpartum
> 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 also ‘sexual abuse in childhood: care considerations for women who are pregnant’ in the A to Z index at www.sahealth.sa.gov.au/perinatal)
> Post-traumatic stress disorder in the perinatal period is highly comorbid with depression
> Antenatal depression and anxiety is clearly associated with an increase risk of Post-traumatic stress disorder
Management

> Maternal mental health is improved for women whose postnatal depression was identified through screening and then follow up managed by trained health professionals\(^{34-36}\).

> Early detection is crucial either by the woman herself via screening in pregnancy or postpartum which can occur with the Edinburgh Postnatal depression scale (EPDS), history taking and psychosocial screening (see ‘screening for perinatal anxiety and depression’ in the A to Z index at [www.sahealth.sa.gov.au/perinatal](http://www.sahealth.sa.gov.au/perinatal)).

> Treatment can be suggested through a woman’s GP or other health counsellors.

> 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, public metropolitan hospitals have access to specialised perinatal mental health services who offer consultation and liaison with midwifery and obstetric staff.

> Non pharmacological treatment options are important in the perinatal period\(^{4, 37}\).

Prevention, early identification and intervention:

> There is little evidence to suggest an intervention to prevent perinatal depression and anxiety. Simple measures for mild depressive or anxiety symptoms 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 are helpful to promote the attachment relationship with her infant which can be affected by maternal mental illness.

> More severe disorders 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 state-wide mother baby unit (telephone 08 70871037). Referral information is available at: [http://www.wch.sa.gov.au/services/az/divisions/mentalhealth/helenmayo/dayptserv/index.html](http://www.wch.sa.gov.au/services/az/divisions/mentalhealth/helenmayo/dayptserv/index.html).

> Urgent specialised mental health referral 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 also ‘suicidal ideation and self harm’ in the A to Z index at [www.sahealth.sa.gov.au/perinatal](http://www.sahealth.sa.gov.au/perinatal)).

> 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. 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. Depression in fathers is also linked to adverse effects on children. Encouraging partners to seek help for themselves is clearly appropriate when problems are identified, and starting points could be through the family general practitioner, or with information from Beyond Blue (listed below).

Resources

- WCHN Perinatal and Infant Mental Health Services at WCH and Helen Mayo House (State-wide service)
- Lyell McEwin Perinatal Infant Mental Health Service
- Flinders Medical Centre
- WCHN – Child and Family Health Services (CaFHS)
- Rural and Remote Telemedicine/Telepsychiatry Unit
- General Practitioner (+/- referral to Mental Health Practitioner)
References


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