# key points

SELECTED BY

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**Common mental health disorders affect around one in** five women during pregnancy and the first year following childbirth. Depression and anxiety disorders are the most prevalent mental health disorders during this period as they are at other times of life. Epidemiological studies suggest that that there is an increase in the incidence of depression in the postpartum period. However, a significant proportion of postnatal depression or anxiety may begin in the antenatal period. The most common postpartum anxiety disorder is generalised anxiety disorder but women may also be affected by obsessive compulsive disorder, panic disorder or post-traumatic stress disorder (PTSD). PTSD can be triggered by a traumatic pregnancy or childbirth.

**Postpartum psychosis, a severe mood disturbance with** psychotic symptoms, affects 1 in 1,000 women and can develop very quickly in the first two weeks postpartum, often requiring urgent admission to a specialised mother and baby unit. It is estimated that more than a third of women with bipolar disorder will have a postpartum relapse and one in six will develop postpartum psychosis. Other risk factors include previous postpartum psychosis and a family history of affective psychosis.

**It is important to distinguish postnatal depression from** baby blues, which is common and requires no treatment, although it is a potential risk factor for postnatal depression. During baby blues the mother typically presents with mood swings ranging from elation to sadness, insomnia, tearfulness, crying spells, irritability, anxiety, and poor concentration. Symptoms develop within 2 to 3 days of delivery, peak on the fifth day, and resolve within 10-14 days.

**The Whooley depression identification questions may** be used to facilitate discussion of emotional problems. If a woman responds positively to either question or there is clinical concern a full assessment should be performed. Use of the Edinburgh Postnatal Depression Scale (EPDS) or the Patient Health Questionnaire (PHQ-9) is recommended. However, a positive score does not equate to a diagnosis of depression and should always prompt further assessment. A sensitive enquiry should be made about domestic violence and abuse, alcohol and drug misuse, and social and interpersonal factors which may make the mother more vulnerable to mental illness. It is essential to ask about thoughts of suicide and self-harm as well as thoughts of harming the baby.

**Postpartum psychosis most often presents as a mixed-** affective, schizoaffective or manic state, with prominent confusion and fluctuating symptoms, although depressive and schizophrenia-like presentations may also occur. If the diagnosis is suspected an urgent referral should be made to secondary care mental health services, preferably the local perinatal mental health service, for immediate assessment, ideally within four hours of referral.