key points

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The postnatal period appears to be associated with higher rates of adjustment disorder, generalised anxiety disorder, and depression. Women who have a history of serious mental illness are at higher risk of developing a postpartum relapse, even if they have been well during pregnancy. Psychiatric causes of maternal death are more common than some direct causes of death.

UK rates increased from 13/100,000 in 2006-2008 to 16/100,000 in 2010-2012, higher than, for example, mortality caused by haemorrhage or anaesthetic complications of childbirth.9 In the period between 2006 and 2008, 67 women died from psychiatric causes. The main cause of death was suicide (29 women).

Postnatal depression is more severe than baby blues, follows a chronic course and may relapse outside the perinatal period. Although 13% of patients already have depression in pregnancy, the majority tend to be diagnosed after delivery; up to 19% from childbirth to three months post partum.

NICE recommends using the Two Question Depression Screen and the Generalized Anxiety Disorder scale from the booking visit through to one year postpartum. A positive response to depression or anxiety questions warrants a full assessment using either PHQ-9 or the Edinburgh Postnatal Depression Scale.

The incidence and relapse rates for bipolar disorder and schizophrenia are probably no higher in pregnant women than in women who are not pregnant. Bipolar disorder may relapse in pregnancy because women decide to stop their medication because of concern about its teratogenic potential. It may also present as a first depressive episode in pregnancy or the postnatal period. In the postpartum period women have a high risk of experiencing a severe relapse.

The incidence of postpartum psychosis is between 0.5 and 1 per 1,000 deliveries and has a sudden and dramatic presentation with delusions, mania, severe depression, or mixed episodes with wide fluctuations of symptoms and severe mood swings. It can present within 90 days after childbirth but usually starts in the first postnatal days, or even in the first hours after giving birth, and leads to high psychiatric admission rates.

A stepped approach to management entails low-key interventions for less severe illnesses, building up to specialist treatments for more severe and risky conditions. Psychological therapies may be preferred over pharmacotherapy in the perinatal period to avoid risks to the child.

Benzodiazepines should be avoided in the perinatal period, except for short-term treatment of severe agitation. Sodium valproate, carbamazepine and lamotrigine should not be given in the perinatal period.