Antenatal depression: expecting a not-so-happy event?

Suffering from depression while you are pregnant is just as serious and common as postnatal depression

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The Times’s investigation into the Eddie Gilfoyle case — he was convicted of murdering his pregnant wife in 1993 — has helped to highlight a medical condition that rarely gets the attention it deserves. While we are all familiar with postnatal depression and the risk to mother and baby, few people know that antenatal depression can be just as serious and is just as common. Indeed, more pregnant women and new mothers commit suicide than die from better-recognised complications of pregnancy, such as infection, high blood pressure and haemorrhage, combined.

Gilfoyle was convicted of hanging his wife in their garage after forcing her to write a suicide note. He protested his innocence but, after considering expert evidence suggesting that suicide was unusual during pregnancy, the police didn’t believe him. Sixteen years later we now know that suicide is one of the biggest threats to the life of a pregnant woman. So why do we pay it so little attention compared with other antenatal complications such as pre-eclampsia?

A British woman has a one-in-four chance of developing at least one episode of clinical depression in her life, and this is most likely to occur during her reproductive years. It has long been recognised that women are particularly vulnerable after they have given birth, and that one woman in ten goes on to develop postnatal depression, which, in its most severe form, can require compulsory hospital admission under the Mental Health Act to protect mother and baby. But since Gilfoyle’s conviction it has become widely accepted that depression is probably just as common before baby is born — it is just more likely to be missed, or attributed to the trials and tribulations of pregnancy, which is partly why The Times has argued that Gilfoyle’s conviction is unsafe.

Tell-tale emotional clues such as tearfulness, irritability and anxiety are put down to “hormones”, while associated somatic symptoms such as poor sleep, loss of appetite and unexplained fatigue are generally attributed to the physical demands of pregnancy — a misattribution that is unlikely to happen in the postnatal period when midwives, health visitors and GPs are extra vigilant about changes in mood or behaviour.

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No pregnant woman is immune but depression is more common in those who have had previous mental health issues. Young single mothers with little social support are more susceptible, too, as are women in unhappy relationships, particularly those in which domestic violence is involved.

The Edinburgh Postnatal Depression Score is a way of screening for depression in women who have given birth and it can be a useful tool in the antenatal period, too. It is a simple questionnaire asking how a woman has felt in a variety of situations over the previous seven days. Each answer is scored and added to give a final tally which gives a good idea of whether the woman is likely to have significant depression. There are ten questions looking at various aspects of mood — for example, the first asks “Have you been able to laugh and see the funny side of things in the past week? Score 0 for answering ‘As much as I always could’, 1 for ‘Not quite as much now’, 2 for ‘Definitely not so much now’ and 3 for ‘Not at all’.”

Another asks about heightened anxiety — a common symptom in depression. “In the past seven days, have you been anxious or worried for no good reason? Score 0 for ‘Not at all’, 1 for ‘Hardly ever’, 2 for ‘Yes, sometimes’ and 3 for ‘Yes, very often’.”

You can complete the full questionnaire at www.patient.co.uk/showdoc/40002172 and it will tot up your scores. Anything up to ten is normal but a score of 13 or more suggests that you are depressed and should seek advice from your GP or midwife. They can assess you more carefully and decide what, if anything, needs to be done.

In the mildest of cases, counselling and support, along with advice to start taking more exercise (not a priority for most pregnant women although a sensible, graded exercise programme can give a significant boost to mood) may be all that is required. Others may be offered cognitive behavioural therapy and some will need to take antidepressants. The threshold at which a doctor would consider prescribing antidepressants during pregnancy is higher than normal because of the additional risk to the developing baby.

Antidepressants, particularly the newer types, have been linked to congenital malformation and withdrawal effects once the baby has been born. Older-generation drugs such as amitriptyline and dosulepin, and the more recent fluoxetine (Prozac) are generally regarded as the safest, but the theoretical risks still have to be carefully balanced against the benefits.

Untreated depression can lead to a host of problems, ranging from an increased likelihood of miscarriage or going into premature labour to self-neglect and suicide.

Fortunately, if dealt with properly, antenatal depression should respond well to treatment, though therapy may well need to be continued up to and beyond the child’s first birthday. The tricky bit is spotting it early.

For more information on depression and the treatments available, visit www.depressionalliance.org