Editorial
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Perinatal Depression

Perinatal Psychiatry is a branch of Consultation Liaison psychiatry dealing with psychiatric problems arising during the obstretrical care of women in pregnancy and the post-partum period. Such a branch appears to occupy a specialized area of scientific interest and may therefore seem to concern a limited portion of psychiatric practice. However, if one takes a closer look at statistics it becomes obvious that this may not be so.

Despite the dated belief that pregnancy protects from psychiatric disturbance, at least one out of ten women (10–15%) will manifest depression during the perinatal period, while the risk of severe depression during pregnancy is between 3.6 and 6.1%. In addition, 60% of women with a history of mood disorder discontinue their medication near conception, but half of them are necessitated to restart them in the course of pregnancy. The following statistics should be kept in mind as well: 20–30% of women of reproductive age use psychiatric medication; over 50% of pregnancies are not scheduled; and, all psychiatric drugs cross the placenta to the fetus and are excreted in milk. This underlines the fact that the prescription of such medication to women of reproductive age requires a complex evaluation.[1]

These well documented numbers make us realize that we are against a public health issue. In Greece we have about 100 thousand deliveries per year. This means that every year about 3000 to 6000 women will manifest a major depression in relation to their pregnancy. In a recent study from our group, 5% of the women that were evaluated with structured psychiatric interviews two months post-partum fulfilled criteria for major depression, and another 7.4% for minor depression. The sample was derived form the general obstetrical population (70% private and 30% public as is the case for Greek women). Nevertheless two thirds of the women who developed depression during the puerperium had a history of previous episode unrelated to childbirth, a rate ten times higher than women who had a history of depression but did not relapse post-partum.[2] If we take into consideration that perinatal depression has a recurrent course and often becomes chronic and that, in developed countries, the main cause of maternal death is suicide (which in severe cases of psychotic depression is combined with infanticide), we come to realize the great need for public education, special training and specialized services. The services required, both on an outpatient as well as an in-patient level (i.e., mother baby units and mother-baby day hospitals) exist in only a few countries and are very rare in Greece.[3]

Proper medical care perinatally aims to maximize the possibilities that a healthy baby will be born and that its mother can be in sound health to provide good care. Perinatal depression is a frequent, predictable and treatable clinical entity but, unless treated appropriately and on time, it may put the mental and physical health of the mother at risk and may jeopardize her ability to take care of her baby, a complication with far reaching consequences for the child's psychological and neurobiological development, as much recent data makes obvious.[4,5]

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