



For better
mental health

Understanding postnatal depression



'I had the common baby blues after my daughters, but it was nothing compared to the crippling depression I had after the birth of my son. I cried constantly and didn't want to know my kids, husband or friends. I wasn't sleeping and was obsessed by housework.'

'Everybody kept saying to me, "Oh, how well you're coping". And yet, behind the closed walls, you think, "Why can't I tell them what's going on?".'

'Late one afternoon, I stood washing up at the kitchen sink. The water was hot. The next thing I remember is that the water was cold and it was dark outside. I was glad that we lived near King's Cross Station, because there were lots of trains and I could walk under one.'

Postnatal depression is very common. Yet far too often, new mothers are left to suffer in silence, struggling on alone, because their problem is not recognised. This booklet explains the possible causes of postnatal depression, describes the signs to look out for, and tells you what can be done to help.



What is postnatal depression?

People expect that having a baby is going to be a source of happiness, and of course it is, and should be. But, as a new mother, you may be very far from feeling this straight away, and this can bring with it huge anxiety. You may well go through a short period of feeling emotional and tearful, which may be brief and manageable (the 'baby blues'), or you may develop deeper and longer-term depression (postnatal depression). Very rarely, a new mother may experience an extremely severe form of depression, known as puerperal psychosis (see p. 16).

The baby blues

New mothers usually get the baby blues two to four days after the birth, and this is so common that it's regarded as normal. You may feel very emotional and liable to burst into tears, for no apparent reason, or for reasons that may seem quite trivial to other people. You may find it difficult to sleep (even when the baby lets you) and you may not feel like eating. You may also feel anxious, sad, guilty, and afraid that you are not up to being a mother.

Doctors suggest that the baby blues may be down to changes in hormone levels that happen after the birth, but others say it's brought on by the experience of being in hospital. Although having the baby blues is distressing, it's important to know that it doesn't last long – usually only a few days. Medical professionals don't usually take it very seriously. If the depression goes on for longer, however, or gets worse, it may be a turning into postnatal depression.

Postnatal depression (PND)

At least one new mother in ten goes through PND, often when the baby is between four and six months old, although it can emerge at any time in the first year. It can come on gradually or all of a sudden, and can range from being relatively mild to very hard-hitting. There is some evidence that about half of these women are afraid to tell health visitors about the way they are feeling because they are afraid it will lead to social services taking away their children, or that they would be seen as bad mothers.

What are the common signs of PND?

You may go through one or more of the following experiences, although it's extremely unlikely that you will go through all of them:

- feeling very low, or despondent, thinking that nothing is any good, that life is a long, grey tunnel, and that there is no hope
- feeling tired and very lethargic, or even quite numb. Not wanting to do anything or take an interest in the outside world
- a sense of inadequacy; feeling unable to cope



- feeling guilty about not coping, or about not loving the baby enough
- being unusually irritable, which makes the guilt worse
- wanting to cry
- losing your appetite, which may go with feeling hungry all the time, but being unable to eat
- difficulty sleeping: either not getting to sleep, waking early, or having vivid nightmares
- being hostile or indifferent to your husband or partner
- being hostile or indifferent to your baby
- losing interest in sex
- having panic attacks, which strike at any time, causing rapid heartbeat, sweaty palms and feelings of sickness or faintness
- an overpowering anxiety, often about things that wouldn't normally bother you, such as being alone in the house
- difficulty in concentrating or making decisions
- physical symptoms, such as stomach pains, headaches and blurred vision
- obsessive fears about the baby's health or wellbeing, or about yourself and other members of the family
- thoughts about death.

Thoughts about death can be very frightening, and may make you feel as if you are going mad or completely out of control. You may be afraid to tell anyone about these feelings. It's important to realise that having these thoughts doesn't mean that you are actually going to harm yourself or your children, although this does happen very occasionally (see p. 16). However difficult it is, the more you can bring these feelings out into the open and talk about them with someone you trust, the less likely you will be to act on them.

PND is assessed, usually by health visitors, using a questionnaire called the Edinburgh Postnatal Depression Scale. This was designed with British women in mind and is not effective with women from non-western cultures, although there is some help in this area; for example, a primary care trust in Sheffield has developed a set of booklets (in five languages) for diagnosing PND in women whose first language is not English, using picture cards to encourage discussion of moods and feelings.



What causes PND?

PND can happen whatever your family circumstances, and whether or not the baby is your first. You may have managed happily with your first baby and yet become depressed after your second, or the other way around. There is no one cause for PND, but a number of different possibilities have been put forward to explain why new mothers may become depressed in this way.

The shock of becoming a mother

Women are often unprepared for the physical impact of childbirth, and yet motherhood has further shocks in store. There are new and daunting skills to learn, and this is only the beginning. You are suddenly responsible, 24-hours a day, for a helpless human being whose only communication is crying, which we as adults associate with distress. Some new mothers become very anxious about their babies, feeling overwhelmed by the responsibility of looking after them, and lying awake at night listening for their breathing and fearful of cot death.

As a new mother, you may find you can't go out without the baby, and that you may not even want to. Neither can you leave the baby alone in the house. Suddenly your own freedom to come and go as you please has disappeared. When you do take the baby out, the pram or buggy turns familiar routes into obstacle-courses, and buses and shops are suddenly hard to use. All too often, you may find yourself alone in the house, with no adults to talk to. And you may feel totally exhausted. All this takes getting used to. Becoming a mother involves many losses, not only of freedom, but also of income, of independence, and of your sense of who you are.

Changed relationships

Becoming a mother can be a huge change of role. It alters the relationship between you and your partner. Two adults, who may have had few joint responsibilities previously, are suddenly parents.

It will affect your relationship with your own mother, too. You're no longer your mother's little girl but, instead, have turned her into a grandmother. This is a further loss, as well as a gain, which both sides have to adjust to.

You may well have given up a job, if only temporarily, and will find yourself financially dependent on someone else, perhaps for the first time in your adult life. Even when the baby is a second or third one, there are still adjustments to be made, because each new baby changes the family as a whole. In a way, it gives birth to a new family, and all its members have to get used to that.

Help with adjusting

Mothers do not enjoy high status in the West, and there are hardly any rituals to honour them, or celebrate their new role. Rituals help us to adjust. An Indian health-worker, now living in the UK, put it as follows:

'During our visit home to Gujerat, my sister-in-law gave birth. She did no housework for 40 days, just lay in bed with the baby, and we, the women of the family, all sat around bringing her presents, singing and gossiping and telling stories. Every day, the midwife came and gave her and the baby a massage.'

Customs like this give the new mother a breathing space to recover from the birth and get to know her new baby. They affirm her in her role as mother, and give her a chance to gain knowledge and skills from other women in the family. And they help raise the self-esteem of these women as mothers. We have lost this.

Twenty years ago women often used to spend a week in hospital following the birth of their baby, recovering, and being fed and supported while they learned to feed and care for the infant; nowadays they often go home on the day of the birth, with little or no professional support. One study of experiences of new mothers suggested that lack of support was a key cause of PND. Home births may mean that more support is available, both from the midwife who attends the birth, and from family and friends.

Lack of support

It's easy to ask too much of mothers and motherhood. On the one hand, society idealises motherhood, requiring mothers to be open-armed, ever-giving sources of food and love. On the other, they are expected to achieve this impossible perfection by magic. Mothering is thought of as instinctive, not something that needs to be learned.

In the past, women learnt about motherhood in the large families that used to be common. When they became mothers, in turn, they could expect to call upon the help of their female relatives, young and old. Nowadays, many new mothers have to cope on their own, with, or without the help of their partner, and often neither of them has any previous experience. Not having these skills can feel like a crippling personal failure.

Other stresses to cope with

If you are under additional strain for any reason, you are more likely to become depressed. The cause could be an illness or death in the family, or because you are moving house or changing your job. Or it could be the result of longer-term difficulties, such as being unemployed, on a low-income or in poor housing.

You may be going through other life experiences which make it harder for you to cope with giving birth. Women who are giving birth in an unfamiliar environment, such as recent immigrants, refugees or asylum seekers, are likely to be more vulnerable to PND. Giving birth in a high tech hospital environment, surrounded by strangers rather than at home with family, brings many extra stresses, and women may feel unable to follow comforting rituals and taboos which are important in traditional cultures.

Evidence suggests that a new mother is more likely to become depressed if she has no-one to confide in, has no job outside the home and has three or more children under 14 years old living with her. These are all factors that involve some kind of loss and low self-esteem.

Difficult labour

If you are unfortunate and have a difficult labour with a long and painful delivery, an unplanned caesarean section or emergency treatment, you may be suffering from a form of post-traumatic stress disorder rather than postnatal depression. The impact of this has been under-estimated, as people may feel that the baby is adequate compensation for the trauma and that you will soon forget the ordeal in the joy of motherhood; but traumatic childbirth may impair your relationships with both your baby and your partner. You may feel acute disappointment that childbirth was not the wonderful experience you were hoping for, and feel angry with the obstetricians and midwives if you felt that the delivery was mismanaged. Many mothers avoid further pregnancy after a negative birth experience. Women who suffer traumatic childbirth should be treated for trauma and helped to put the experience behind them, to minimise the risk of developing long-term depression.

You may also feel upset at the appearance of your body after childbirth. You may have unrealistic expectations about how soon your body may return to its normal size and shape after giving birth, and be upset by stretch marks or scars. Usually weight is lost gradually over a period of months rather than weeks, and scars will fade with time.

Childhood experiences

Your own childhood experiences can have a huge influence on the present. Sometimes, long-buried hurts can be forced to the surface by the shock of giving birth. In particular, if you were separated from your own mother for any length of time before the age of 10 or 11, you could be more vulnerable to postnatal depression. The separation could be because of illness, death or war. Or it could have been through being sent away to relatives (for the birth of a sibling, perhaps) or to boarding school. Some of these events might have been seen as unremarkable at the time, but they may still have been traumatic for you as a child. When these old sorrows emerge, in the form of depression, it can be frightening and bewildering. It's also potentially healing. With the right kind of support, you may be able to let go and move on. (See Mind's booklet *Understanding talking treatments*.)

Hormonal upheaval

The hormones oestrogen and progesterone affect our emotions. Levels of progesterone are very high during pregnancy and some doctors believe that PND can be caused by the sudden drop in progesterone after the birth. But when women were given progesterone to try and prevent depression it had the reverse effect and got worse, whereas treatment with an oestradiol patch is found to be helpful.

Perinatal depression

The term 'perinatal' means around the time of birth – both before and after. Although depression is thought to be most commonly experienced by new mothers soon after the birth, some women experience depression during pregnancy, and research has suggested symptom scores for depression are higher during pregnancy than after the birth. One study suggests depression may in fact be more common before the birth than afterwards.

Diet

There is some evidence to show that a lack of certain nutrients during pregnancy can lead to depression; these include omega 3 oils (found in oily fish, seeds and nuts), magnesium (leafy green vegetables and seeds) and zinc (seeds and nuts). Poorly controlled blood sugar levels – caused by irregular eating or omitting the right types of food – can also have the same effect. (See *Take care of yourself*, on p. 10.)

What can I do to help myself get better?

PND usually gets better in time, although it may take up to a year. Love, support and nurture from family, friends and community can be vital in helping you to cope.

Someone to talk to

It's important to feel understood and supported. A sympathetic listener, who can hear about your feelings and worries without judging, can bring enormous relief. It could be a health visitor, a community psychiatric nurse, a counsellor, or a volunteer from a self-help organisation (see *Useful organisations*, on p. 18).



Health visitors have a responsibility towards families with children under five and can be an invaluable source of help and advice. Some have training in counselling skills. Some run groups for new mothers. As a new mother, you should already be in contact with them.

Meeting other parents

One of the most helpful things is to talk to other mothers and fathers – it can be very reassuring to find that all new parents share the same anxieties and frustrations. Meeting others in the same position as you will give you a chance to share skills and experiences, to realise you are not alone, and above all to get some emotional and practical support. It can also help to affirm you in your new role. Do try and keep in touch with people you may have met at your antenatal classes, and go to parent-and-baby groups locally. There are many organisations that can put local mothers in touch with each other, including Meet a Mum Association and Home-Start (see *Useful organisations*, on p. 18, for details). Having a baby can be a wonderful way to make new friends.

Take care of yourself

This is easier said than done with a small baby in the house, but do accept offers of help from relatives and friends. Difficulty in concentrating and lack of appetite are part of the depression. The first makes it difficult to prepare food; the second makes it difficult to eat. Lack of food makes the condition worse. You may be anaemic, which will make you feel tired and make it harder to relate to your baby. You are also quite likely to be lacking vitamin B, calcium and magnesium. If you are finding it difficult to prepare food, you may not be getting adequate nutrients and it may be worth taking vitamin and mineral supplements to make sure you are getting enough of these. For a nutritional action plan for postnatal depression see Food for the Brain's website (www.foodforthebrain.org).

Lack of sleep, anxiety and poor concentration may make you less able to concentrate and reduce your reaction times, making you more vulnerable to accidents (be careful about driving or using machinery). If your baby takes a bottle, try to

get someone to take over the night feeds, if only for a night or two. If you are breastfeeding only, you can have the baby's cot next to your bed, so that you can feed with the minimum of disruption. In time, you and the baby will fall into a natural rhythm of sleeping and waking, and this makes the night feeds much less stressful and tiring. Don't try to do too much round the house; you and the baby are much more important. If you are having a lot of broken nights, try to sleep when the baby does, and, if at all possible, have people to help you out with daily responsibilities, so that you can rest during the day.

If lack of sleep has become habitual, your GP may also consider prescribing sleeping pills to help you, but these should not be taken if you are breast feeding because they are excreted in breast milk, and are absorbed by the baby. Lethargy and weight loss have been reported in an infant exposed to diazepam; oxazepam may be slightly less risky. Any sleeping pills should be taken for brief periods only, and preferably not for several nights in a row, in order to avoid becoming dependent on them (see Mind's booklet, *Making sense of sleeping pills and minor tranquillisers*).

Physical activity is an antidepressant, especially if it's enjoyable. Try swimming, dance, yoga or T'ai Chi. These are often available through your local authority's adult or community education programme, and there may be a crèche available.

Learn to relax

There are various techniques you can learn, to help you become more relaxed and deal with anxious feelings. These may be simple breathing or relaxation techniques, such as those taught in antenatal classes. (See Mind's booklet *The Mind guide to relaxation*, or *The Mind guide to managing stress*.) Or give yourself a relaxing bath with candles and scented foam while the baby is asleep or is being entertained by someone else. Find something to do, just for the fun of it. It doesn't matter whether it's five minutes with your feet up and a glass of orange juice, or an aerobics workout, as long as it gives you pleasure. This recharges your batteries and reminds you, and others, that you deserve good things.



What sort of treatment is available?

PND is not only a distressing condition, it's a serious and disabling one, which can be nipped in the bud if it's spotted early. It can be hugely reassuring to both you and your partner to know what's wrong. If PND isn't acknowledged and addressed, it's likely to last longer and be more severe than it need be, and this can affect the relationship between you and your baby. You need help, but you may need encouragement to seek it, and support in getting it. Feeling reluctant to ask for help is part of the problem.

Possible sources of help include your GP, midwife, health visitor, community psychiatric nurse, psychiatrist, psychotherapist or counsellor, or complementary practitioner. Experts suggest that the best conventional treatment for PND may be a combination of practical support and advice, counselling or psychotherapy, and if necessary, antidepressants or ECT.

The National Institute for Health and Clinical Excellence (NICE) has produced guidelines on postnatal care (October 2006) as well as on antenatal and postnatal mental health (April 2007), which can be found on their website. The guidelines on antenatal and postnatal care say that healthcare professionals should, before and during pregnancy if possible, and after the birth, ask specific questions designed to detect signs of depression, and follow this up as appropriate. Talking therapies should be more readily available to women who are pregnant or breastfeeding because of the increased risk of using medicines at these times. The guidelines discuss issues to be considered in relation to women with pre-existing mental health problems who wish to become pregnant, are already pregnant or are breast feeding, and list the risks associated with the different types of psychiatric drugs.

Counselling and psychotherapy

Talking treatments, such as counselling and psychotherapy, offer you the opportunity to look at the underlying factors that have contributed to the PND, as well as helping you to change the way you feel. Many GPs have a counsellor or psychotherapist attached to the practice. They can also refer patients to a psychiatrist or psychologist on the NHS. Various organisations offer talking treatments, and some of them operate a low-fee scheme for those who can't afford to pay. (For more information, see Mind's booklet, *Understanding talking treatments*.) Cognitive behaviour therapy is increasingly popular as a short-term treatment, providing you with practical strategies for dealing with problems (see Mind's booklet *Understanding cognitive behaviour therapy [CBT]*.)

Prescription medicine

A GP can prescribe various kinds of medication to help, and it's important to discuss this fully, beforehand, and to keep monitoring progress. It is very important to remember that medication may enter breast milk, and if you are breast-feeding you will need to bear this in mind when deciding whether or not to take it. Some drugs have known effects on infants, while others appear to be quite safe, so it is important to discuss this with your doctor. Manufacturers advise that the following drugs should be avoided while breast feeding: doxepin, citalopram, duloxetine, escitalopram, fluoxetine, fluvoxamine, venlafaxine, lithium, mirtazapine, and reboxetine. Benzodiazepine tranquillisers and sleeping pills, and bupropion should also be avoided if possible if you are breast feeding. All other drugs should be used with caution; talk to your doctor or a pharmacist if you need more advice about a particular drug. (Also see the *Making sense of series*, on p. 21, for more details on individual drugs.)

If you do decide to try medication, it may be necessary to try different drugs to achieve the best results. All antidepressants take time to work. They also all have possible side effects, and when you stop taking them you should withdraw slowly, to avoid possible withdrawal effects which can be unpleasant. If you do take them, they can be very effective, and you should be prepared to take them for at least six months.

ECT

ECT is a controversial treatment, but some psychiatrists favour it for PND because when it works it can produce good results very quickly. But of course many people are nervous of it, and it does not work for everyone. (See Mind's booklet, *Making sense of ECT.*)

Complementary therapies

Complementary therapies are well worth looking into. Many women have found cranial osteopathy, herbal remedies and homeopathy helpful. Massage, reflexology and aromatherapy may also be worth trying. These are holistic therapies, acting on the whole person to support the body and spirit in healing, rather than intervening with a chemical fix.



How can family and friends help?

It may be both difficult and frustrating to live with someone who has PND. It may be helpful to think of the birth of the baby as a crisis that everyone has to adjust to, to avoid blaming any one family member for the distress. Think of it as a patch of stormy weather that has to be got through. And be prepared to seek help from wherever you can, both for yourself and for the depressed mother.

Perhaps the most important thing is to recognise that someone suffering from PND may need encouragement to seek help, and support to get it. Help her to find someone to talk to in depth, and reassure her that she is not going mad and that she will get better.

Make sure she knows that you will support her, and not abandon her. Practical steps include helping her to get enough food, rest, and exercise. Try to ensure that she doesn't spend too much time alone to cope with the baby. A sense of isolation can be the most stressful aspect of mothering. Support the idea that she deserves to have a daily treat, and enable her to get it. One way might be to offer her a massage. This is a great help in promoting relaxation and restoring a sense of wellbeing.

The following will make her depression worse:

- telling her to pull herself together – she is already feeling bad about herself, and doing her best
- walking out on her, however difficult or impossible she is
- leaving her alone with the baby for long periods
- plying her with alcohol or encouraging her to drink too much.

Try to find out as much as you can about postnatal depression, and, if necessary, be prepared to fight for more resources. Be prepared to talk about it, so that the problem does not remain invisible.

What about fathers?



Although postnatal depression is mainly a problem for mothers, with causes that are at least partly physiological, in recent years it has increasingly been recognised that new fathers also become depressed. It has been suggested that as many as 1 in 25 new fathers are affected. The causes include the pressures of fatherhood, increased responsibility, the expense of having children and the change in life-style that it brings, the changed relationship with their partners, as well as lack of sleep and increased workload at home. Research has shown that in families where fathers were depressed soon after the birth, the children were at increased risk of emotional and behavioural problems, and boys were more affected than girls.

Depression in fathers is frequently associated with postnatal depression in mothers, and as with mothers, the father's depression may begin during the pregnancy, when relationships are already changing and they may feel left out while their partner is receiving increased attention as a pregnant woman. Studies have found that both midwives and health visitors may see fathers as problematic and potentially violent, and may marginalise them while working with the family. This may be exacerbated by the fact that men often express depression as hostility, and frequently lack close relationships with people they can confide in. Few services exist for men, although awareness and understanding of this problem is improving slowly.



What is puerperal psychosis?

This is a serious psychiatric illness, which is fortunately quite rare, occurring in about one in 1,000 births. It is similar in some ways to bipolar disorder, and may take the form of mania, severe depression with delusions, confusion or stupor, or rapid changes in mood between these extremes.

It usually starts quite suddenly a few weeks after the birth, with the mother being very restless, excited or elated and unable to sleep. She may be confused and disorientated, and may find it difficult to relate to her environment, or may fail to recognise friends or family members. This may make it very difficult for her to bond with her baby. She may have delusions (for example, she may believe that she is the Virgin Mary and is going to save the world) or hallucinations (she may see or hear things that others can't). She may misconstrue things that are happening around her – for example, she may think her baby is being taken away from her, when staff are simply taking it for a sleep or a feed. She may be manic (cleaning the house at three o'clock in the morning) or have wild mood swings from high to low. Her behaviour may become increasingly bizarre and disturbing to those around her, and she may lose touch with reality. It soon becomes very clear that she needs help, and medical and social support.

There is some evidence that this condition runs in families, and women with a previous or family history of mental health problems (for example, a diagnosis of bipolar disorder) are at a higher risk of developing puerperal psychosis. However, it often appears with no warning. It is slightly more common in first rather than later pregnancies, and one experience of puerperal psychosis does not necessarily mean that a woman is likely to have it again after subsequent pregnancies. It is important to get appropriate help as quickly as possible, as there is an increased risk of suicide in this condition, and some mothers also kill their babies.

Treatment may involve being in hospital, in a mother and baby unit within a psychiatric ward where this is available, and will usually include stabilising drugs such as lithium, an antipsychotic such as olanzapine, or antidepressants. As many areas do not have mother and baby units it is sometimes necessary to separate the mother from her baby while she is being treated. Clearly this is undesirable and the period of separation should be as short as possible.

Medication needs to be thought about carefully if the mother is very anxious to continue breastfeeding her baby, and it may be necessary for mothers not to breastfeed if they are to be treated with certain drugs. All published advice states that antipsychotics and lithium should be avoided while breastfeeding. (See *Mind's Making sense* series, for more details, on p. 21.) Doctors may want to use ECT which can be effective, and does mean that breastfeeding can continue. Psychosocial treatments such as cognitive behaviour therapy may also be used. Most women recover within a few weeks of onset, but it may take a long time to get over it completely.

References

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- NICE, 2007, Antenatal and postnatal mental health: clinical management and service guidance, NICE Guideline 45.
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Useful organisations

Mind

Mind is the leading mental health organisation in England and Wales, providing a unique range of services through its local associations, to enable people with experience of mental distress to have a better quality of life. For more information about any mental health issues, including details of your nearest local Mind association, contact the Mind website: www.mind.org.uk or *MindinfoLine* on 0845 766 0163.

Action on Puerperal Psychosis

web: www.neuroscience.bham.ac.uk/research/app/
Division of Neuroscience, University of Birmingham. Network of women who have suffered puerperal psychosis and who are willing to receive correspondence about research projects, information sheets and newsletters

The Association for Post Natal Illness

145 Dawes Road, London SW6 7EB
tel. 020 7386 0868 web: www.apni.org
Provides support to mothers with postnatal depression

The Breastfeeding Network

PO Box 11126, Paisley, PA2 8YB
supporterline: 0844 412 4664
supporterline in Bengali/Sylheti: 07944 879 759
web: www.breastfeedingnetwork.org.uk
An independent source of support and information for breastfeeding women and others.

British Association for Counselling and Psychotherapy (BACP)

tel. 0870 443 5252 web: www.bacp.co.uk
Contact for details of local practitioners

British Confederation of Psychotherapists (BCP)

tel. 020 7267 3626 web: www.bcp.org.uk

A network of psychoanalytical psychotherapy societies. Can provide a register of members

Family Welfare Association

tel. 020 7254 6251 web: www.fwa.org.uk

Advice and practical support for families facing a range of complex issues

Fatherhood Institute

web: www.fatherhoodinstitute.org

The UK's fatherhood think-tank, providing news, training information, policy updates, research summaries and guides for supporting fathers and their families

Home-Start

Home-Start UK, 2 Salisbury Road, Leicester LE1 7QR

freephone: 0800 068 63 68 tel. 0116 233 9955

web: www.home-start.org.uk

Informal and friendly with local support networks for families with young children

MAMA (Meet a Mum Association)

helpline: 0845 120 3746 web: www.mama.co.uk

Offers information, one-to-one support and support groups, especially for lonely and isolated mothers

The National Childbirth Trust (NCT)

Alexandra House, Oldham Terrace, London W3 6NH

pregnancy and birth line: 0870 444 8709

breastfeeding line: 0870 444 8708 enquiry line: 0870 444 8707

web: www.nctpregnancyandbabycare.com

Offers supportive groups to women before and after birth, and groups for depressed mothers

Perinatal Illness UK

PO Box 49769, London WC1H 9WH

web: www.pni-uk.com

For women and their families who have or think they have any kind of perinatal illness, including antenatal depression, postnatal depression, puerperal psychosis and birth trauma. Online message boards and chatrooms are available

United Kingdom Council for Psychotherapy (UKCP)

tel. 020 7014 9955 web: www.psychotherapy.org.uk

Regional lists of psychotherapists are available free.

Useful websites

www.depression-in-pregnancy.org.uk

For women who experience depression during pregnancy.

www.birthtraumaassociation.org.uk

For women who have experienced traumatic childbirth. Also has a fathers/partners section

www.netmums.com

Web-based parenting organisation helping parents share information and advice

www.nice.org.uk

For guidelines on treatments

Further reading

- Coping with postnatal depression* Dr Sandra L Wheatley (Sheldon Press 2005) £7.99
- The food and mood handbook* Amanda Geary (Thorsons 2001) £12.99
- How to cope with relationship problems* (Mind 2006) £1
- How to cope with sleep problems* (Mind 2005) £1
- How to cope with suicidal feelings* (Mind 2007) £1
- How to help someone who is suicidal* (Mind 2004) £1
- How to look after yourself* (Mind 2006) £1
- How to parent when you're in a crisis* (Mind 2004) £1
- How to rebuild your life after breakdown* (Mind 2004) £1
- How to recognise the early signs of mental distress* (Mind 2008) £1
- How to stop worrying* (Mind 2006) £1
- The kitchen shrink: foods and recipes for a healthy mind* Natalie Savona (DMP 2003) £10.99
- Making sense of antidepressants* (Mind 2006) £2.50
- Making sense of antipsychotics (major tranquillisers)* (Mind 2004) £3.50
- Making sense of coming off psychiatric drugs* (Mind 2005) £2.50
- Making sense of cognitive behaviour therapy* (Mind 2007) £2.50
- Making sense of counselling* (Mind 2008) £2.50
- Making sense of ECT* (Mind 2003) £2.50
- Making sense of sleeping pills and minor tranquillisers* (Mind 2007) £2.50
- Making sense of lithium* (Mind 2004) £2.50
- Making sense of psychotherapy and psychoanalysis* (Mind 2004) £2.50

continued overleaf...

Further reading continued

- The Mind guide to food and mood* (Mind 2006) £1
- The Mind guide to managing stress* (Mind 2006) £1
- The Mind guide to physical activity* (Mind 2006) £1
- The Mind guide to relaxation* (Mind 2006) £1
- Overcoming depression: A self-help guide using cognitive-behavioural techniques* P. Gilbert (Constable 2000) £9.99
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Mind's mission

- Our vision is of a society that promotes and protects good mental health for all, and that treats people with experience of mental distress fairly, positively, and with respect.
- The needs and experiences of people with mental distress drive our work and we make sure their voice is heard by those who influence change.
- Our independence gives us the freedom to stand up and speak out on the real issues that affect daily lives.
- We provide information and support, campaign to improve policy and attitudes and, in partnership with independent local Mind associations, develop local services.
- We do all this to make it possible for people who experience mental distress to live full lives, and play their full part in society.

For details of your nearest Mind association and of local services contact Mind's helpline, *MindinfoLine*: **0845 766 0163** Monday to Friday 9.15am to 5.15pm. Speech-impaired or Deaf enquirers can contact us on the same number (if you are using BT Textdirect, add the prefix 18001). For interpretation, *MindinfoLine* has access to 100 languages via Language Line.

Scottish Association for Mental Health tel. 0141 568 7000

Northern Ireland Association for Mental Health tel. 028 9032 8474

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