NATIONAL INSTITUTE FOR HEALTH AND CLINICAL EXCELLENCE

Centre for Clinical Practice

Review of Clinical Guideline (CG45) Antenatal and postnatal mental health – clinical management and service guidance

1. Background information

Guideline issue date: Feb 2007 (re-issued April 2007)
Update review date: July 2011
National Collaborating Centre: Mental Health

2. Review recommendation

- The guidance should be considered for an update.

3. Factors influencing the decision

Literature search

1. From initial intelligence gathering and a high-level randomised control trial (RCT) search clinical areas, approximately 200 studies were identified relevant to the guideline scope. The identified studies related to the following key clinical areas within the guideline:
   - Detection and screening tools for depression and anxiety
   - Safety concerns of pharmacological treatments
   - Interventions for women with subthreshold symptoms of depression and/or anxiety

2. Two extra clinical questions were developed based on the qualitative feedback from other NICE departments and the views expressed by the Guideline Development Group, for more focused literature searches.

- Management of traumatic birth (viewing/holding stillborn)
- Substance and/or alcohol use in pregnancy

3. Current recommendation suggested mothers of stillborn should not be routinely encouraged to view or hold the dead infant. However, the overall management of traumatic birth had not been appropriately addressed in the guideline.

4. In addition, feedback from members of the GDG suggested a new area (the management of substance and/or alcohol use in pregnancy) that is not currently covered in the guideline.

Guideline Development Group and National Collaborating Centre perspective

5. A questionnaire was distributed to GDG members and the National Collaborating Centre to consult them on the need for an update of the guideline. The NCCMH also consulted with the GDG chairs of the relevant NICE guidelines CG51, CG52, CG115. Two responses were received with respondents highlighting validity of detection and screening tools, and the management of substance and alcohol misuse. One GDG member felt that other NICE guidelines (CG110, CG115) had limited guidance on the management of substance and alcohol misuse in pregnancy, therefore this issue was worth including in this guideline update.

Implementation and post publication feedback

6. Enquiries were received from post-publication feedback, most of which were routine. Key themes emerging from post-publication feedback included – recommendation 1.3.1.4 (viewing of stillborn). This feedback contributed towards the development of the clinical questions as described above.

7. There are concerns around the wording of this recommendation.

8. No new evidence was identified through post publication enquiries or implementation feedback that would indicate a change to the current recommendation.

Anti-discrimination and equalities considerations

9. No evidence was identified to indicate that the guideline scope does not comply with anti-discrimination and equalities legislation. The original scope contains recommendations for women who are suffering from mental health problems during pregnancy and the postnatal period, and the needs of families and carers in the support of women who have mental health problems.

Summary of Stakeholder Feedback

Review proposal put to consultees:
The guideline should be updated at this time.

10. In total, 18 stakeholders commented on the review proposal recommendation during the 2 week consultation period. 17 stakeholders agreed with the review proposal recommendation that this guideline should be updated at this time.

11. Literature was submitted through stakeholder consultation relating to:

- Risk factors and symptoms of post-traumatic stress disorder (PTSD) in women after childbirth.

12. During consultation, stakeholders agreed with the review proposal that the following areas should be considered for an update of the guideline:

- detection and screening tools
- safety concerns for medication
- management of traumatic birth

- substance and alcohol use in pregnancy

13. During consultation, new areas to consider in an update of the guideline were also highlighted including:

- infants' mental health outcomes
- mother's recovery and functioning

Conclusion

14. The large support received from the stakeholder feedback reflects that the areas identified in this review will impact significantly on practice, resources and patient outcomes. Thus, this guideline should be considered for an update.

Relationship to quality standards

15. This topic has not currently been referred for a quality standard.

Fergus Macbeth – Centre Director
Sarah Willett – Associate Director
Review conducted by NCC for Mental Health

July 2011

APPENDIX 1

The following NICE guidance is related to CG45:

Guidance	Review date
Related NICE guidance not included in CG45	
CG113 Generalised anxiety disorder and panic disorder (with or without agoraphobia) in adults.	January 2014
CG90 Depression: the treatment and management of depression in adults (update).	October 2012
CG110 Pregnancy and complex social factors	September 2013
CG26 Post-traumatic stress disorder (PTSD)	November 2011
CG51, 52 Drug misuse: opioid detoxification and psychosocial interventions	July 2013
CG115 Alcohol dependence and harmful alcohol use	February 2014
CG37 Postnatal care	February 2012

APPENDIX 2

NATIONAL INSTITUTE FOR HEALTH AND CLINICAL EXCELLENCE

Review of Clinical Guideline (CG45) - Antenatal and postnatal mental health

Guideline Review Consultation Comments Table
01 – 14 June 2011

Stakeholder	Agree with proposal to update?	Comments Please insert each new comment in a new row.	Comments on areas excluded from original scope	Comments on equality issues
Lancashire Care NHS Foundation Trust	Agree	Agree that all 5 areas of guideline highlighted in conclusion should be reviewed		
United Kingdom and Ireland Marce Society	Agree	UKIMS have reviewed the document and we strongly support the proposal to update CG45.	Including substance and alcohol would be a good addition and we support this development	No issues
United Kingdom and Ireland Marce Society		The evidence base has considerably changed since the original guidance was published, particularly in the area of psychotropic medications and pregnancy. A number of the previous recommendations, particularly with reference to individual medications, would need to be looked at again and are likely to need to be changed.		
United Kingdom and		The multi professional make up of the UKIMS membership means that we are		

Stakeholder	Agree with proposal to update?	Comments Please insert each new comment in a new row.	Comments on areas excluded from original scope	Comments on equality issues
Ireland Marce Society		ideally placed to consider the influence that the guidelines have had across professional groups. One area that has been very controversial is the advice regarding the use of the EPDS as a screening tool in pregnancy and the postpartum and revisiting these recommendations would be a request of many of our membership.		
United Kingdom and Ireland Marce Society		UKIMS feel that the membership of the CDG is key and should include a spectrum of academic and professionals – from those with expertise in clinical psychopharmacology, through to health visitors and midwifes dealing with sub threshold symptoms of depression and anxiety. UKIMS would wish to nominate individuals we consider would contribute greatly to the CDG.		
British Psychological Society, The	Yes	We note that the recommendation is to review the guidance at this time, and the Society would not disagree with this recommendation.		
Royal College of Midwives	Agree	The Royal College of Midwives agree with the proposal that the guideline should be considered for an update at this time.		
British Dietetic Association		We have circulated this consultation to our membership and our members have not identified a reason to review this guidance at this time.		

Stakeholder	Agree with proposal to update?	Comments Please insert each new comment in a new row.	Comments on areas excluded from original scope	Comments on equality issues
		We would however, be grateful if you could inform us of the outcome of the consultation and of any further consultations		
Association For Family Therapy and Systemic Practice in the UK (AFT)	Yes	Agree that there should be a review, given the evidence in this document, and the way that relationships are being valued.		
British Association for Psychopharmacology	Yes	The BAP strongly supports the proposal to update the CG45.		
British Association for Psychopharmacology		The management of perinatal mental health problems is an important area in which there is much uncertainty and a considerable need for clinical guidance. The BAP have developed a highly successful 'master class' in Perinatal Psychiatry in recent years. It is clear that there is considerable interest in this area and that there is on-going uncertainty amongst primary and secondary health care professionals. This includes a number of areas in which the evidence base has substantially changed since 2007, or which were not covered in the original guidance. In clinical practice, this results in some cases in differences	Since the publication of CG45 there has been a considerable amount of new data – particularly regarding the reproductive safety of psychotropic medication. It is clear that a number of the recommendations of the previous guidelines need to be revisited and are likely to need to be changed.	

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		between the NICE guidance and what is currently advised by specialists in this area.		
British Association for Psychopharmacology		The BAP believe that membership of the CDG for the revision will be key and would wish to nominate members of BAP with extensive experience of clinical reproductive psychopharmacology for this role.		
British Association for Psychopharmacology			Revisiting the issue of the use of detection and screening tools for depression and anxiety in the perinatal period is needed as is a consideration of the evidence on interventions for women with subthreshold symptoms of depression and anxiety.	
British Association for Psychopharmacology			We also support extending the guidelines to substance use in pregnancy.	
Royal College of General Practitioners	Agree	Should there be an examination of how the Whooley questions have performed (as recommended in the last guideline with little evidence!)		
British Association for Behavioural & Cognitive Psychotherapi	Agree but with reference to comments	The points refer to the identification and understanding of OCD around this time including the importance of good risk assessment.		

Stakeholder	Agree with proposal to update?	Comments Please insert each new comment in a new row.	Comments on areas excluded from original scope	Comments on equality issues
es (BABCP)				
British Association for Behavioural & Cognitive Psychotherapies (BABCP)		In the current guideline, the references to OCD during pregnancy and postnatally mention a review by Abramowitz (2003) which highlights a raised prevalence of OCD in the perinatal period, mostly based on retrospective reports. Recent studies which have attempted cross sectional studies have also suggested a raised rate of approximately 4% relative to the prevalence in the general population (e.g. Torres et al, 1.2%). Even though the studies are not brilliant they are reasonably consistent postnatally in identifying a raised rate, suggesting that this is a relatively frequent problem exacerbated or triggered by pregnancy and/or childbirth.		
British Association for Behavioural & Cognitive Psychotherapies (BABCP)		It would be useful to highlight that contamination and intrusive thoughts are the most common types but all types are possible. As Abramowitz (2003) points out, contamination is more common for pregnancy onset, whilst intrusive thoughts are common as a postnatal presentation. Excessive concerns re contamination can be hard to spot in pregnancy but can lead to restriction of diet and activities to a significant extent.		

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		Although thoughts of harm are common in depression and in the normal population, it's the reaction to them that distinguishes if it's OCD. The issues we have encountered in terms of diagnosis, particularly (but not only) regarding thoughts of harm are: this problem is rarely enquired about and when symptoms are disclosed, it is often diagnosed as postnatal depression and sometimes as psychosis (75% of the people in our admittedly very small scale unpublished trial did not have the correct primary diagnosis), preventing people getting CBT for OCD in a timely fashion or at all. We have recently worked with two cases of OCD focused on intrusive thoughts of deliberate harm which had been diagnosed as psychosis or psychotic depression and the mums were treated as a risk to their babies which perpetuated the OCD. The issues around diagnosis and disclosure are therefore important barriers to help seeking. We are currently researching the impact on the mother infant relationship including attachment but have no published data yet. and i know of no other published investigation of this. Most of the mums in our study report interference in everyday tasks of parenting to varying degrees. almost all Mums reported their parenting		

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		was affected. we have recently shown in a published case series that mums perceive parenting to be helped by standard CBT.		
British Association for Behavioural & Cognitive Psychotherapies (BABCP)		So in summary, an increased awareness of postnatal ocd as an issue amongst mental health specialists and other workers in primary care could i think have a big impact.		
Birth Trauma Association	Agree	We warmly welcome the inclusion of traumatic birth in the proposed update of the APMH. We would hope that the update will look not only at the management of stillbirth but other causes of PTSD arising from childbirth.		
Birth Trauma Association		We would ask that consideration be given to expanding the research questions to include strategies for communicating risks and benefits of different interventions to women who may be suffering psychological distress or mental health issues.		
Royal College of Paediatrics and Child Health	Agree	The College supports review of evidence of benefit/harm to fetus/neonate of treatments.		

Stakeholder	Agree with proposal to update?	Comments Please insert each new comment in a new row.	Comments on areas excluded from original scope	Comments on equality issues
		We support review of evidence of benefit/harm to mother being offered to hold her baby and review of wording.		
Royal College of Paediatrics and Child Health		The area of stillbirths and, probably, early neonatal deaths needs addressing more in depth. We note the area of substance misuse (especially alcohol) is increasingly problematic in postnatal care – Fetal Alcohol Spectrum Disorder is probably underrecognised.	Maybe postnatal mental health in relation to early neonatal death.	
Royal College of Obstetricians and Gynaecologists	Agree	The membership of the Guideline Development Group includes only one lay person (service-user) and no midwife or health visitor. Provision of mental health services in pregnancy is very patchy and primary care seems often to be reluctant to get involved, whilst at the same time some GPs are cross about being side-stepped. Much of what it says seems sensible but perhaps some reinforcement is necessary in some areas. Particular issues: 1. There seems (in the guideline and in practice) no distinction between major and minor mental health problems. Women with major psychosis and especially bipolar disorder are at major risk of mortality and need very experienced input; women with more		

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		minor degrees of mental health issues aren't such a risk, but nevertheless appropriate management will minimise morbidity; women who have once previously been a bit depressed as a result of major critical life events decades ago probably don't need any action at all. 2. Not everyone needs referring to an obstetrician and if they do we need to think about which obstetrician. In our unit we have an interested obstetrician who does a regular joint clinic with a psychiatrist. 3. The guideline covers PTSD (by referring you to a different guideline) but doesn't specifically address obstetrically derived PTSD. Some units now offer special debriefing clinics; it would be interesting to see how effective they were. 4. There seemed to be no consideration of tocophobia/tokophobia. The CS GDG has made us very aware of the hoops women are expected to jump through to get CS on demand. During the GDG process we had input from a specialist clinical psychologist who assured us that 80% of tocophobic women can be turned round by psychological interventions during pregnancy, which sounds much better		

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		than the “three wise-men juries” being set up to consider such requests in some units.		
Royal College of Psychiatrists	Agree	The Royal College of Psychiatrists strongly supports the proposal to update CG45.	The College would strongly support the inclusion of the management of substance and alcohol use during pregnancy.	
Royal College of Psychiatrists			There was criticism following the publication of CG45 that the role of fathers and assessment of their needs was not included. The College would support the inclusion of this area in the revised document.	
Royal College of Psychiatrists			Infant Mental health is of profound importance and there is a growing body of evidence and support for paying particular attention to this time in an infant’s life. The College strongly supports the inclusion of this area in the revised guideline.	
Royal College of Psychiatrists		Emphasis needs to be placed in the revised document on the need for a shared recognition (to include A&E staff, emergency psychiatric staff, midwifery, primary care etc) of the relapse pattern (rapid and severe) in the Perinatal period of women with severe mental illness particularly those women with affective disorders.		
Royal College		The College would support the re-iteration		

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of Psychiatrists		of and increased emphasis being placed on the need for women to be able to access psychological therapies promptly both in pregnancy and in the postnatal periods. The reduced desirability of using psychotropic medication and the need for timely resolution of symptoms in this period reinforces this view.		
Royal College of Psychiatrists		There has been considerable change in the evidence base of psychotropic medication in pregnancy and breastfeeding since publication of CG45. The previous recommendations will require substantial revision.		
Royal College of Psychiatrists			The needs of women from BME and refugee groups should be addressed. There is evidence that they have high levels of mental health problems in the perinatal period accompanied by difficulties in accessing services. A recent DOH document highlights the issues for service development in this area.	
Royal College of Psychiatrists		The use of detection and prediction tools for mental health problems in the Perinatal period needs to be revisited.		
Royal College of Psychiatrists		The College believes that membership of the guideline development group should include Perinatal psychiatrists. The Section of Perinatal psychiatry would be very happy to help identify and nominate		

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		appropriate member/s for the group.		
Royal College of Psychiatrists		Interventions for women with sub-threshold symptoms of anxiety and depression need to be explored and considered.		
Royal College of Nursing	Agree	The new evidence which has been identified should be taken into account as it may result in changes to the recommendations. We therefore agree that the guideline should be reviewed.		
Department of Health		We wish to confirm that the Department of Health has no substantive comments to make regarding this consultation.		
GDG member	Agree	Agree with all areas identified	Substance misuse recommendations much needed	
GDG member		Rapidly changing and complex evidence on risks – particularly in relation to medication – points to need for clinicians at all levels to have access to advice from experts who can help balance risks and benefits of management choices (eg whether/what to prescribe in primary or secondary care, when to admit and where to, what to advise in relation to risks of illness relapse). The stepped care model suggests that specialist advice is only available when each of the previous steps has been climbed. This model of delivery does not fit the evidence or indeed good		

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		practice in the field		
GDG member			More emphasis is needed on recovery and outcomes for mother - particularly for mothers functioning as a parent - and infant outcomes	
GDG member		The current guidance advises detection of women with past histories of severe and psychotic illnesses but does not draw on the evidence of what can be done to reduce risk of relapse of such illnesses (no data specific to APMH but plenty for these illnesses in general, which can be applied with modification for this context)		
GDG member		Recent trials have refined the evidence on acceptability and relative benefits of medications and psychological therapies for depression postnatally. These findings need to be included in the updating exercise.		
NHS Direct	Agree			
Electivecesarean.com	Agree	The comments I have written in the adjacent column ("comments on areas excluded from original scope") relate to: 1) Clinical area 3:- Interventions for women with subthreshold symptoms of depression and/or anxiety 2) Clinical area 4:- Management of traumatic birth: Potential new evidence or concerns (relating to	**Pg.10 (1.1.1.2)** NICE: '*Providing and using information effectively …explore the woman's ideas, concerns and expectations and regularly check her understanding of the issues*' It would be useful to include a statement here on the specific issue of tokophobia.	

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		overall management of traumatic birth) that may need to be considered for inclusion in the guideline Therefore, in the adjacent column, I have noted the section and page number as they refer to the original NICE guideline, in order to help identify the areas. For some of the comments, it may be the case that the area IS included in the update proposal, and I am just suggesting some expansion to the coverage of these areas. Thank you.	Please look at this Royal College of Psychiatrists' press release from January 01, 2000: http://www.rcpsych.ac.uk/press/pressreleasearchive/pr55.aspx (Text:) *'Tokophobia' is an intense anxiety or fear of death which leads to some women dreading and avoiding childbirth despite desperately wanting a baby. A study of a series of 26 cases of women suffering from this condition is published in the January issue of the British Journal of Psychiatry. It concludes that:* *Tokophobia is a distressing psychological condition which may be overlooked* *It is associated with anxiety, depression, post-traumatic stress disorder (PTSD) and bonding disorders* *Close liaison between the obstetrician and the psychiatrist is imperative* *Subjects for the study were referred from obstetricians in the West Midlands and from psychiatrists on the mother and baby unit at the Queen Elizabeth Psychiatric Hospital in Birmingham. They were seen over a two-year period in their homes by the*	

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			same psychiatrist who was not the treating doctor. *24 of the women in the study were married and 24 had had all their children with the same partner.* *Primary tokophobia. Eight of the women had a dread of childbirth which pre-dated pregnancy and had begun in adolescence. Sexual relations were normal but contraceptive use was scrupulous. Four of these women planned their pregnancy despite their intense fears; and two had an overwhelming desire to be a mother which overpowered their avoidance but did not allay their fear.* *Most women with primary tokophobia strongly desired a Caesarian birth. Four achieved this, bonded well with their baby and enjoyed excellent psychological health. Three women endured vaginal deliveries against their will; all suffered postnatal depression, two suffered symptoms of PTSD and two had delayed bonding with their infants.* *Secondary tokophobia occurs after a traumatic or distressing delivery. 14 women in the study developed a dread of childbirth after a previous delivery. Their dilemma was that the family felt incomplete but they were terrified of a*	

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			further delivery. Nevertheless 13 of them proceeded with further pregnancies, of whom three had miscarriages (and felt enormous relief that delivery was avoided). All 13 women were extremely anxious during their pregnancies. *11 of the women in this study group arranged a Caesarian birth; one had a successful vaginal delivery and a good psychological outcome; and the other suffered postnatal depression, PTSD and a bonding disorder with her baby.* *Four women developed tokophobia as a symptom of depression in the prenatal period and believed that they were unable to deliver their baby – if made to, they would die. Two who tried to end their pregnancy were treated psychologically and recovered. One woman who responded well to antidepressants arranged a Caesarian birth and bonded well to her baby. By contrast, another women who declined antidepressant medication and was refused a Caesarian had a traumatic vaginal delivery, suffered from postnatal depression and felt detached from her baby.* *Five women in the sample reported sexual abuse in childhood and three a traumatic rape. The authors comment*	

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			that a history of sexual abuse may be associated with an aversion to routine obstetric care associated with primary tokophobia or tokophobia as a symptom of depression. The trauma of a vaginal delivery may cause a resurgence of memories of abuse and contribute to secondary tokophobia. Two women in the study terminated a pregnancy because they could not face delivery, even though both babies were much wanted. This outcome may be the only choice in the absence of an empathic professional listener or access to relevant medical literature. There was a high rate of hyperemesis gravidarum in the study, and a psychological component to this has been postulated. It refers to this study: K Hofberg and I Brockington, "Tokophobia: an unreasoning dread of childbirth. A series of 26 cases," The British Journal of Psychiatry: The Journal of Mental Science 176 (January 2000): 83-85. http://www.ncbi.nlm.nih.gov/pubmed/10789333 In addition, the following studies might be useful to consider for background	

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			knowledge during the gathering of evidence: Mothers' Satisfaction with Planned Vaginal and Planned Cesarean Birth. Blomquist JL, Quiroz LH, Macmillan D, McCullough A, HandaVL. Am J Perinatol. 2011 Mar 4. http://www.ncbi.nlm.nih.gov/pubmed/21380993 Ingela Wiklund, Gunnar Edman, and Ellika Andolf, “Cesarean section on maternal request: reasons for the request, self-estimated health, expectations, experience of birth and signs of depression among first-time mothers,” Acta Obstetricia Et Gynecologica Scandinavica 86, no. 4 (2007): 451-456. http://www.ncbi.nlm.nih.gov/pubmed/17486467 E L Ryding, K Wijma, and B Wijma, “Psychological impact of emergency cesarean section in comparison with elective cesarean section, instrumental and normal vaginal delivery,” Journal of Psychosomatic Obstetrics and Gynaecology 19, no. 3 (September 1998): 135-144. http://www.ncbi.nlm.nih.gov/pubmed/9	

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			844844	
			Pg.15 (1.3.1.3) NICE: '*Prevention of mental disorders*' It would be useful to include a statement here on the specific issue of tokophobia and its potential to lead to a psychological problem postpartum – if not recognised and supported (or perhaps deemed sufficient to be mentioned in CG13?). And given the example studies below, it appears that more research in this area is needed – in the sense that in order to prevent, we need to recognise what may lead to psychological problems: Risk factors in pregnancy for post-traumatic stress and depression after childbirth. Söderquist J, Wijma B, Thorbert G, Wijma K. BJOG. 2009 Apr;116(5):672-80. Epub 2009 Feb 10. Sweden http://www.ncbi.nlm.nih.gov/pubmed/19220236 …One month postpartum, 12 (1.3%) women had post-traumatic stress (met	

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			symptom criteria B, C, and D for post-traumatic stress disorder according to Diagnostic and statistical manual of mental disorders, 4th edition [DSM-IV]). The most important risk factors in pregnancy were depression in early pregnancy (OR=16.3), severe fear of childbirth (OR=6.2), and 'pre'-traumatic stress (in view of the forthcoming delivery) in late pregnancy (OR=12.5). The prevalence of depression was 5.6%. Post-traumatic stress and depression were positively related 1 month postpartum and were predicted by mainly the same factors… Risk factors for post-traumatic stress and depression after childbirth can be assessed in early pregnancy. Post-traumatic stress and depression also seem to share the same underlying vulnerability factors. Depressive symptoms and symptoms of post-traumatic stress disorder in women after childbirth. Zaers S, Waschke M, Ehlert U. J Psychosom Obstet Gynaecol. 2008 Mar;29(1):61-71. Switzerland http://www.ncbi.nlm.nih.gov/pubmed/18266166 This study examined the course of psychological problems in women from	

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			late pregnancy to six months postpartum, the rates of psychiatric, especially depressive and post-traumatic stress symptoms and possible related antecedent variables. During late pregnancy, one to three days postpartum, six weeks and six months postpartum, 47 of the 60 participating women completed a battery of questionnaires including the General Health Questionnaire, the State-Trait Anxiety Inventory, the Edinburgh Postnatal Depression Scale, and the PTSD Symptom Scale. In general, most women recovered from psychiatric and somatic problems over the period of investigation. However, depressive and post-traumatic stress symptoms in particular were not found to decline significantly. Six weeks postpartum, 22% of the women had depressive symptoms, with this figure remaining at 21.3% six months postpartum. In addition, 6% of the women studied reported clinically significant PTSD symptoms at six weeks postpartum with 14.9% reporting such symptoms at six months postpartum. The most important predictor for depressive and post-traumatic stress symptoms was the block variable "anxiety in late	

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			pregnancy". Other predictors were the variables "psychiatric symptoms in late pregnancy", "critical life events" and the "experience of delivery". The results of our study show a high prevalence rate of psychiatric symptoms in women after childbirth and suggest, besides the experience of the delivery itself, a vulnerability or predisposing history that makes the development of psychiatric symptoms after childbirth more probable. Childbirth and the development of acute trauma symptoms: incidence and contributing factors. Creedy DK, Shochet IM, Horsfall J. Birth. 2000 Jun;27(2):104-11. Australia. http://www.ncbi.nlm.nih.gov/pubmed/11251488 Posttraumatic stress disorder after childbirth is a poorly recognized phenomenon. Women who experienced both a high level of obstetric intervention and dissatisfaction with their intrapartum care were more likely to develop trauma symptoms than women who received a high level of obstetric intervention or women who perceived their care to be inadequate. These findings should prompt a serious	

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			review of intrusive obstetric intervention during labor and delivery, and the care provided to birthing women. Post-traumatic stress disorder due to childbirth: the aftermath. Beck CT. Nurs Res. 2004 Jul-Aug;53(4):216-24. USA http://www.ncbi.nlm.nih.gov/pubmed/15266160 Childbirth qualifies as an extreme traumatic stressor that can result in post-traumatic stress disorder. The reported prevalence of post-traumatic stress disorder after childbirth ranges from 1.5% to 6%... Mothers with post-traumatic stress disorder attributable to childbirth struggle to survive each day while battling terrifying nightmares and flashbacks of the birth, anger, anxiety, depression, and painful isolation from the world of motherhood… This glimpse into the lives of mothers with post-traumatic stress disorder attributable to childbirth provides an impetus to increase research efforts in this neglected area. Post-traumatic stress disorder after childbirth: the phenomenon of	

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			traumatic birth. Reynolds JL. CMAJ. 1997 Mar 15;156(6):831-5. Canada. http://www.ncbi.nlm.nih.gov/pubmed/9084390 CHILDBIRTH CAN BE A VERY PAINFUL EXPERIENCE, often associated with feelings of being out of control. It should not, therefore, be surprising that childbirth may be traumatic for some women. Most women recover quickly post partum; others appear to have a more difficult time. The author asserts that post-traumatic stress disorder (PTSD) may occur after childbirth. He calls this variant of PTSD a "traumatic birth experience." There is very little literature on this topic. The evidence available is from case series, qualitative research and studies of women seeking elective cesarean section for psychologic reasons. Elective cesarean section exemplifies the avoidance behaviour typical of PTSD. There are many ways that health care professionals, including physicians, obstetric nurses, midwives, psychologists, psychiatrists and social workers, can address this phenomenon. These include taking a careful history to determine whether a	

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			woman has experienced trauma that could place her at risk for a traumatic birth experience; providing excellent pain control during childbirth and careful postpartum care that includes understanding the woman's birth experience; and ruling out postpartum depression. Much more research is needed in this area. Posttraumatic stress following childbirth: a review. Olde E, van der Hart O, Kleber R, van Son M. Clin Psychol Rev. 2006 Jan;26(1):1-16. Epub 2005 Sep 19. The Netherlands http://www.ncbi.nlm.nih.gov/pubmed/16176853 …Case studies and quantitative studies confirm that childbirth may be experienced as so emotionally intense that it can lead to the development of posttraumatic stress symptoms or even a PTSD-profile. Among the identified risk factors were a history of psychological problems, trait anxiety, obstetric procedures, negative aspects in staff-mother contact, feelings of loss of control over the situation, and lack of partner support. The conclusion of the current review is twofold. First, traumatic reactions to childbirth are an	

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			important public health issue. Secondly, studying childbirth offers opportunity to prospectively study the development of posttraumatic stress reactions. [Psychologic effects of traumatic live deliveries]. Pantlen A, Rohde A. Zentralbl Gynakol. 2001 Jan;123(1):42-7. Germany http://www.ncbi.nlm.nih.gov/pubmed/11385911 Psychological symptoms postpartum were reported frequently. Traumatically experienced childbirth can be responsible for specific short-term or long-term symptoms. In individual cases, a PTSD can develop after a traumatic delivery with long-term negative consequences for the health and mental condition of the mother, the mother-child-relationship and the desire for further pregnancy. In such cases, a specific psychotherapeutic treatment is always necessary. The longitudinal course of post-traumatic stress after childbirth. Söderquist J, Wijma B, Wijma K. J Psychosom Obstet Gynaecol. 2006 Jun;27(2):113-9. Sweden http://www.ncbi.nlm.nih.gov/pubmed/1	

Stakeholder	Agree with proposal to update?	Comments Please insert each new comment in a new row.	Comments on areas excluded from original scope	Comments on equality issues
			6808086 …In pregnancy, depression, severe fear of childbirth, 'pre'-traumatic stress, previous counseling related to pregnancy/childbirth, and self-reported previous psychological problems were associated with an increased risk of having post-traumatic stress within 1-11 months postpartum. Sum-scores of post-traumatic stress did not decrease over time among women who at least once had post-traumatic stress (criteria B, C, and D) within 1-11 months postpartum. Women with post-traumatic stress also showed a decrease in perceived social support over time postpartum.	
			Pg.16 (1.3.1.3) NICE: '*take into account the effect of the birth on the partner.*' Please include, in consideration of the evidence: Karen Nicholls and Susan Ayers, "Childbirth-related post-traumatic stress disorder in couples: a qualitative study," British Journal of Health Psychology 12, no. Pt 4 (November 2007): 491-509.	

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			Also, in addition to the effect on the partner, it might also be useful to look at the effect on the child too; here is an example study to be considered: Cristie Glasheen, Gale A Richardson, and Anthony Fabio, “A systematic review of the effects of postnatal maternal anxiety on children,” Archives of Women's Mental Health 13, no. 1 (February 2010): 61-74.	

These organisations were approached but did not respond:

Academic Division of Midwifery, University of Nottingham
Action on Pre-Eclampsia
All Wales Birth Centre Group
Anglesey Local Health Board
Association for Improvements in Maternity Services (AIMS)
Association for Infant Mental Health
Association for Post Natal Illness
Association for Psychoanalytic Psychotherapy in the NHS (APP)
Association of Chartered Physiotherapists in Women's Health
Association of Child Psychotherapists
Association of the British Pharmaceuticals Industry (ABPI)
Avon and Wiltshire Mental Health Partnership NHS Trust
Avon and Wiltshire MHP NHS Trust
Baby Lifeline
Barnsley PCT
Barton Surgery
BMJ

Bradford District Care Trust
Bristol Health Services Plan
British Association for Counselling and Psychotherapy
British Association of Art Therapists
British Association of Perinatal Medicine
British Association of Psychodrama and Sociodrama (BPA)
British Maternal and Fetal Medicine Society (BMFMS)
British Medical Association (BMA)
British National Formulary (BNF)
British Paediatric Mental Health Group of the Royal College of Paediatrics and Child Health
Calderdale PCT
Cambridge University Hospitals NHS Foundation Trust (Addenbrookes)
Cambridgeshire & Peterborough Mental Health Trust
Camden and Islington Mental Health and Social Care Trust
Camden PCT, Postnatal Depression Steering Group
Care Quality Commission (CQC)
Care Services Improvement Partnership/National Social Inclusion Programme Action 16 (CSIP)
Central Area of North Wales NHS Trust
City Hospitals NHS Trust
Cochrane Pregnancy & Childbirth Group
Colchester Primary Care Trust
College of Mental Health Pharmacy
College of Occupational Therapists
Community Practitioners and Health Visitors Association
Confidential Enquiry into Maternal & Child Health (CEMACH)
Connecting for Health
Co-operative Pharmacy Association
Cotswold and Vale PCT
Counselling and Psychotherapy Trust (registered charity No. 1063175)
Craven Harrogate and Rural District PCT
Critical Psychiatry Network
Croydon PCT
Department of Health, Social Services & Public Safety, Northern Ireland (DHSSPSNI)
Det Norske Veritas - NHSLA Schemes
Devon Partnership NHS Trust
Devon PCT
Doncaster and South Humber Healthcare NHS Trust
Dudley Beacon & Castle Primary Care Trust
East Sussex Hospitals Acute Trust
Eaton Foundation

Eli Lilly and Company Ltd
English National Forum of LSA Midwifery Officers
Evidence based Midwifery Network
Faculty of Public Health
Fibroid Network Charity
Food for the Brain Foundation
Foundation for the Study of Infant Deaths
GE Healthcare
George Eilot Hosptal Trust
Gloucestershire Hospitals NHS Trust
Gloucestershire LINk
Gloucestershire Partnership NHS Trust
Great Western Hospitals NHS Foundation Trust
Greater Manchester West Mental Health NHS Foundation Trust
Hampshire Partnership NHS Foundation Trust
Healthcare Improvement Scotland
Healthcare Quality Improvement Partnership
Herefordshire Primary Care Trust
Hertfordshire Partnership NHS Trust
Humber NHS Foundation Trust
Independent Healthcare Advisory Services
Independent Midwives UK
Kent & Medway NHS and Social Care Partnership Trust
Lambeth PCT
Leeds Acute Trust
Liverpool PCT
Liverpool Womens NHS Foundation Trust
London and the South Perinatal Psychiatry Clinical Network
Lundbeck Ltd
Maidstone and Tunbridge Wells NHS Trust
Manchester Children's Hospital Trust
Maternity and Mental Health Network
Medicines and Healthcare Products Regulatory Agency (MHRA)
Medway NHS Foundation Trust
Meet-A-Mum Association PND Helpline
Mental Health Act Commission
Mental Health Foundation
Mental Health Nurses Association
Merck Sharp & Dohme (Formerly Organon)
Mid and West Regional Maternity Service Liasion Committee (MSLC)

MIDIRS (Midwives Information & Resource Service)
Midwifery Studies Research Unit
MIND
Ministry of Defence (MoD)
Multiple Births Foundation
National Childbirth Trust (NCT)
National Council for Disabled People, Black, Minority and Ethnic Community (Equalities)
National Institute for Mental Health in England (NIMHE)
National Patient Safety Agency (NPSA)
National Perinatal Epidemiology Unit
National Screening Committee
National Treatment Agency for Substance Misuse
Netmums
NETSCC, Health Technology Assessment
Newcastle PCT
Newcastle, North Tyneside & Northumberland Mental Health Trust
NHS Clinical Knowledge Summaries Service (SCHIN)
NHS Lincolnshire
NHS Milton Keynes
NHS Plus
NHS Sheffield
Niger Delta University
Norfolk and Waveney Mental Health Partnership NHS Trust
North Cumbria Maternal MH Alliance
North Essex Mental Health Trust
North Staffordshire Combined Healthcare NHS Trust
North Tees and Hartlepool Acute Trust
Northampton Primary Care NHS Trust
Nottinghamshire Acute Trust
Nottinghamshire Healthcare NHS Trust
Nutrition Society
Obstetric Anaesthetists Association
Oxleas NHS FoundationTrust
OXPIP
Pelvic Partnership, The
Peninsula Primary Care Psychology & Counselling Services
PERIGON Healthcare Ltd
Pharmacosmos
PNI ORG UK
Positively Pregnant

Post Natal Illness Organisation (PNI)
Post Natal Illness Support & Help Association
Princess Alexandra Hospital NHS Trust
Public Health Wales
Queen Mary's Hospital NHS Trust (Sidcup)
Regional Maternity Survey Office
Rochdale Primary Care Trust
Rotherham NHS Foundation Trust
Rotherham Primary Care Trust
Royal Bolton Hospitals NHS Foundation Trust
Royal College of Anaesthetists
Royal College of General Practitioners Wales
Royal College of Pathologists
Royal College of Physicians London
Royal College of Radiologists
Royal College of Surgeons of England
Royal Pharmaceutical Society of Great Britain
Safeline
Samaritans
Sandwell & West Birmingham Hospitals NHS Trust
SANE
Scottish Intercollegiate Guidelines Network (SIGN)
Servier Laboratories Ltd
Sheffield Care Trust - Sheffield Birth Centres group
Sheffield PCT
Sheffield Perinatal Mental health service
Sheffield Teaching Hospitals NHS Foundation Trust
Social Care Institute for Excellence (SCIE)
Society for Academic Primary Care
South Asian Health Foundation
South Devon Acute Trust
South East Essex PCT
South Essex Partnership NHS Foundation Trust
South West Kent Primary Care Trust
South West Yorkshire Partnership NHS Foundation Trust
Southern Health & Social Care Trust
Spacelabs Healthcare
SSAFA Forces Help
Staffordshire Moorlands PCT
Stockport PCT

Suffolk Mental Health Partnership NHS Trust
Sure Start Ashfield
Sure Start Tamworth
Surrey and Border Partnership Trust
Sussex Partnership NHS Foundation Trust
Tees Esk & Wear Valleys NHS Trust
The Royal Society of Medicine
Trafford Primary Care Trusts
UK Clinical Pharmacy Association (UKCPA)
UK National Screening Committee
UK Specialised Services Public Health Network
United Kingdom Council for Psychotherapy
United Lincolnshire Hospitals NHS Trust
University College London Hospitals (UCLH) Acute Trust
University of the West of England
VBAC Information and Support
Victim Support
Welsh Assembly Government
Welsh Scientific Advisory Committee (WSAC)
West London Mental Health NHS Trust
West Middlesex University NHS Trust
Western Cheshire Primary Care Trust
Wets Herfordshire Hospitals Trust
Worcestershire Acute Hospitals NHS Trust
Worcestershire Mental Health Partnership NHS Trust
www.electivecaesarean.com
Wyre Forest Primary Care Trust
York Teaching Hospital NHS Foundation Trust
Yorkshire and Humber Local Supervising Authorities (LSA)
Young Minds