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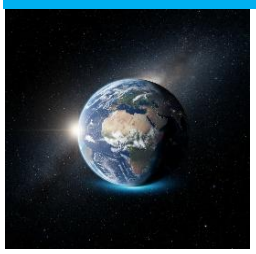

Journal of Education, Health and Sport. eISSN 2391-8306.

Journal Home Page
https://apcz.umk.pl/JEHS/index

APANOWICZ, Lena, MAZUR, Joanna, BUŁKA, Zofia, MICHALIK, Zuzanna, KAPELKA, Klaudia, MALIK, Stanisław, PADUCH, Przemysław, KŁOS, Dawid, LEJA, Duszan, CZECH, Klaudia, ZDROJEWSKA, Kaja, GOGÓL-FIJAŁ, Klaudia and BIAŁOWĄS, Patrycja. A Comparative Analysis of Pharmacological and Non-Pharmacological Treatments for Perinatal Depression. Journal of Education, Health and Sport. 2026;91:70699. eISSN 2391-8306. https://doi.org/10.12775/JEHS.2026.91.70699

The journal has had 40 points in Minister of Science and Higher Education of Poland parametric evaluation. Annex to the announcement of the Minister of Education and Science of 05.01.2024 No. 32318. Has a Journal's Unique Identifier: 201159. Scientific disciplines assigned: Physical culture sciences (Field of medical and health sciences); Health Sciences (Field of medical and health sciences).
Punkty Ministerialne 40 punktów. Załącznik do komunikatu Ministra Nauki i Szkolnictwa Wyższego z dnia 05.01.2024 Lp. 32318. Posiada Unikatowy Identyfikator Czasopisma: 201159. Przypisane dyscypliny naukowe: Nauki o kulturze fizycznej (Dziedzina nauk medycznych i nauk o zdrowiu); Nauki o zdrowiu (Dziedzina nauk medycznych i nauk o zdrowiu).
The authors declare that there is no conflict of interests regarding the publication of this paper.
Received: 09.04.2026. Revised: 04.05.2026. Accepted: 05.05.2026. Published: 07.05.2026.

A Comparative Analysis of Pharmacological and Non-Pharmacological Treatments for Perinatal Depression

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Abstract

Introduction: Perinatal depression is stated to be one of the most prevalent psychiatric disorders during pregnancy and postpartum. It is associated with a negative impact on maternal, infant and the overall family health. Due to limited pharmacotherapy and growing interest in non-pharmacological approaches, more and more attention is given to lifestyle factors in prevention and management.

Aim: This literature review aims to evaluate the impact of lifestyle factors including supplementation, physical activity, as well as pharmacotherapy on the risk of perinatal depression and severity of symptoms, along with an analysis of their role as components of adjunctive therapy.

Materials and methods: A comprehensive literature search was conducted using PubMed, SCOPUS, Web of Science and ScienceDirect including publications up to November 2025. Randomised controlled trials, meta-analyses and review articles were taken under consideration. The searches were analysed in order to assess impact of supplementation (omega-3 fatty acids, folic acid, vitamin D, iron, zinc, probiotics) and physical activity on perinatal depression symptoms.

Results: Available data indicate that certain interventions, such as Vitamin D, iron, zinc and probiotics supplementation might have beneficial effects on decreasing perinatal depressive symptoms. Vitamin D supplementation and probiotics demonstrated a moderate effect on perinatal depression outcomes. Physical activity is associated with a moderate perinatal depression symptoms reduction. Efficiency of selective serotonin reuptake inhibitors (SSRI) is limited, therefore some new pharmacological approaches including neurosteroides or ketamine are under investigation.

Conclusion: Lifestyle factors might constitute significant complementation of perinatal depression therapy. However, their role in prevention is unambiguous
and requires further research. The most effective therapeutic approach should be multimodal and include both non-pharmacological interventions and pharmacotherapy.

Materials and Methods:

A literature review was conducted using publications available in the Pubmed as well as those indexed in Web of Science and SCOPUS containing publications up to November 2025. The search was performed using the following keywords: *perinatal depression, postpartum depression, antenatal depression, lifestyle factors, supplementation, omega-3 fatty acids, vitamin D, probiotics, physical activity, exercise, SSRI, randomized controlled trial (RCT).* Randomised controlled trials, meta-analyses and review articles were taken under consideration, while animal studies and non-English publications were excluded. Selection was divided into three stages: screening of titles, abstracts and full-text articles. The review included research assessing influence of supplementation, physical activity and pharmacotherapy particularly in relation to SSRI efficiency and novel treatment approaches for perinatal depression. All above mentioned steps were conducted by eleven independent researchers.

Introduction:

The term perinatal depression refers to depression occurring during pregnancy, postpartum and up to one year postpartum. It is a mental disorder affecting approximately one in seven females during perinatal period. Perinatal depression is defined as mood disorder which according to Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR) includes both prenatal and postnatal depression, as it may occur during pregnancy, within the first year after childbirth and in both periods (1).

Perinatal depression is characterized by symptoms like: constant sadness, lack of previous interest, low self-esteem, loss of appetite, sleeping disorders, anxiety and irritation, negative attitude towards an infant and feeling of guilt. Moreover, females suffering from perinatal depression might develop a problem with creating a bond with a baby and feeling of worthlessness and hopelessness. Perinatal depression symptoms initiate as a major depressive episode (MDE) during pregnancy or during four weeks postpartum. To make a diagnosis, symptoms ought to last longer than fourteen days and they should significantly worsen a female's quality of life (2).
Patients with perinatal depression may also present psychotic symptoms including delusions and hallucinations (3).

Previously mentioned symptoms can have a negative impact on mother’s, children’s and the whole family’s quality of life. Untreated depression may last many months and lead to notable aggravation of mental condition and daily function. What is more, during pregnancy it can be associated with more frequent preterm birth (PTB), low birth weight (LBW) or preeclampsia. Depression causes release of stress hormones such as cortisol, which can lead to disruption of oxygen and nutrients flow resulting in intrauterine growth restriction (IUGR), PTB or LBW (4). Depression is the most common mental disorder during the perinatal period. Perinatal depression is connected with increased risk of suicide which is stated to be the second most common cause of death. Perinatal depression affects between 6.5% to 20% of females

worldwide. It occurs more commonly in less developed countries. According to a meta-analysis evaluating the occurrence of perinatal depression in different countries, the number of females suffering from perinatal depression in China, Japan and USA was respectively 21.4%, 14% and 8.6% (3).

Exact perinatal depression reasons remain unknown, but several risk factors which may contribute to development of perinatal depression were found. The development of perinatal depression is influenced by hormonal changes that occur during pregnancy, as well as genetic and psychological factors, stressful life events, which may act as triggers for the condition. Scientifically proven hormonal factors are a decrease of estrogen and progesterone levels after delivery (5). Psychological risk factors are previously diagnosed depression, negative attitude toward the newborn and history of sexual abuse. If it comes to obstetrics risk factors, development of depression is more probable among females with high risk pregnancy, hospitalizations during pregnancy and traumatic childbirth. The risk of perinatal depression is also increased by social factors such as lack of support, domestic violence and very young maternal age. Other risk factors are: poor dietary habits, lack of physical activity, vitamin B6 deficiency, sleep deprivation and family history of mental disorders (6).

According to the high prevalence of perinatal depression and its complications it is recommended to conduct screening tests at least twice: first time during pregnancy possibly as soon as possible and second time within 6-12 weeks postpartum. The most popular screening test is The Edinburgh Postnatal Depression Scale (EPDS). Nevertheless, according to evidence based medicine it is recommended to expand the screening to more precise diagnostics methods including clinical interview with the patient (7).

Perinatal depression should be differentiated from “baby blues” which is defined as postpartum sadness manifested as mild and transient depressive symptoms as well as dysphoria occurring during first days postpartum (8). “Baby blues” symptoms last no longer than 10 days (9).
Our study is a review of the current scientific literature on the role of lifestyle factors, including, among others, supplementation and physical activity, in the risk of developing perinatal depression.

1. THE IMPACT OF SUPPLEMENTATION ON THE OCCURRENCE OF PERINATAL DEPRESSION

1.1. Omega-3 fatty acids supplementation

A meta-analysis of randomized controlled trials by Roel J. T. Mocking and colleagues found that omega-3 fatty acids show significant but small positive influence on perinatal depression. It is suggested that omega-3 fatty acids supplementation’s clinical significance is population-dependent. The greater benefits from omega-3 fatty acids supplementation were observed among females with previously diagnosed depression and postnatal depression. During the pregnancy no significant effect of omega-3 fatty acids supplementation on the development of depression was confirmed. That is why authors do not recommend omega-3 fatty acids supplementation as a prevention of perinatal depression. However, they can not exclude the

positive impact of supplementation of omega-3 fatty acids on supporting treatment of depression (10).

The results show that PUFAs supplementation might be an effective and supportive method of perinatal depression management. According to one of meta-analyses it is stated that optimal dose resulting in positive effect is 2 grams of
docosahexaenoic acid (DHA) and Eicosapentaenoic acid (EPA) Supplementation should be administered at the initial stage of pregnancy (11).

Based on previously mentioned meta-analyses, omega-3 fatty acids supplementation may have moderate impact as a supporting approach for perinatal depression. The role in perinatal depression prevention remains unclear and needs further randomized controlled trials.

1.2 Folic acid supplementation

Studies demonstrate that the level of folic acid is lower among people with depression in comparison with healthy people. Pregnancy is the time of the biggest exposure to folic acid deficiency. Xingyi Jin meta-analysis analysed fifteen searches and negative correlation between concentration of folic acid and depression symptoms were. observed. It was concluded that continuous folic acid supplementation during pregnancy might decrease presence of perinatal depression symptoms. In 2015 a cohort study was conducted in which 4046 females participated. Participants were divided into three groups; first one did not supplement folic acid, the second administered folic acid during one trimester and the third group supplemented that active substance through two or three trimesters of pregnancy. Presence of symptoms were assessed three months after delivery using The Edinburgh Postnatal Depression Scale (EPDS). Two cut-off points were adopted - females that received ≥ 10 points were considered to have mild depressive symptoms while those who scored ≥ 13 points considered to exhibit moderate to severe symptoms. Prevalence of mild depressive symptoms stood at 20.2% meanwhile for moderate to severe symptoms amounted to 11%. In a group of participants who did not use folic acid higher EPDS scores were observed: EDPS
≥10 26.8% (versus 18.1% in both groups that supplemented folic acid) and EPDS ≥13 15.7% (versus approximately 9% in both groups that supplemented folic acid). Interfering factors were included during the adjusted analysis, in which correlation between folic acid and perinatal depression is no longer statistically significant. The conclusions stated no statistically significant influence of folic acid during pregnancy on perinatal depression symptoms. The data suggested lower frequency of depressive symptoms among females supplementing folic acid, but after considering other factors this conclusion was refuted. According to the described meta-analysis folic acid supplementation can not be considered as an effective method of perinatal depression prevention. It is however crucial to supplement that substance in order to avoid neural tube defects (12).

1.3 Vitamin D3 supplementation

The aim of the randomised control trial was to assess the impact of vitamin D3 supplementation of perinatal depression occurrence among females. The study was conducted among females under perinatal care in Iran. Including criteria were: age ≥ 18 years old, no history of mental and internal illnesses, singleton pregnancy with a live fetus, no pregnancy-related complications, gestational age of 26-28 weeks at the time of enrollment in the study, and a depression scale

score of 0-13 points.The Edinburgh Postnatal Depression Scale (EPDS) was used in the trail. In the study there were 169 participants, who were divided into Vitamin D3 group and placebo group. Patients receiving Vitamin D3 were administered the dose of 2000 IU from 26-28 gestational age up to the day of delivery. 25-hydroxyvitamin D concentration was indicated at the beginning of the trial and on the day of giving labour. Both groups initially had similar concentrations of Vitamin D3. On the day of delivery the Vitamin D3 group had a notably higher level of 25-hydroxyvitamin D compared to the placebo group. Severity of symptoms was assessed during the search four times - in 26-28 gestational age, in 38-40 weeks, four and eight weeks postpartum. Intensity of depressive symptoms in the first measurement did not vary between the groups. In 38-40 weeks of pregnancy, four and eight weeks postpartum severity of perinatal depression symptoms were lower among females supplementing Vitamin D3 than in the placebo group. The conclusions suggest that Vitamin D3 supplementation in the early stage of pregnancy leads to decrease in depressive symptoms intensity. Authors recommend necessity of conducting further studies on females at the risk of perinatal depression, on the bigger study group and at more than one research center (13)

1.4 Zinc supplementation

The study by Chieko Aoki and colleagues analyzed the effect of zinc supplementation on the presence of perinatal depression symptoms assessed using The Edinburgh Postnatal Depression Scale (EPDS). The main aim was to indicate levels of zinc, haemoglobin and hematocrit among females who underwent cesarean section and had postnatal anemia. What is more, the secondary aim was assessment of correlation of zinc concentration on perinatal depression. According to the study zinc supplementation increased the level of this substance in the bloodstream and decreased three times the severity of depressive symptoms. i (OR=0,249; 95% CI:0,062–0,988; p=0,048) (14)

1.5 Iron supplementation

Another supplement that potentially might have a positive impact on perinatal depression approach is iron. Meta-analysis by Yanran Tian and colleagues evaluated the influence of iron on depressive symptoms. Authors came to the conclusion that there is a statistically significant impact. They recommend iron supplementation as a perinatal depression prevention but they also suggest that further investigation must be conducted (15).

1.6 Lactobacillus rhamnosus HN001 supplementation

R F Slykerman and colleagues analyzed the impact of Lactobacillus rhamnosus HN001 supplied during pregnancy on symptoms of postnatal depression and anxiety. A randomised, double-blinded control study was evaluated. 423 females from New Zealand recruited between 14 and 16 gestational age participated in the study. Patients administered Lactobacillus rhamnosus HN001 or placebo everyday starting supplementation on the day of including the study and ending six months postpartum. To assess the depressive and anxiety symptoms modified versions of The Edinburgh Postnatal Depression Scale (EPDS) and State Trait Anxiety Inventory (STAI) were used. Mothers in the probiotic group presented notably lower intensity of depressive symptoms. It can be concluded that Lactobacillus rhamnosus HN001 might be an effective part of treatment that results in decreasing postnatal depression symptoms (16).

Table 1. The effect of *Lactobacillus rhamnosus* HN001 on symptoms of depression and anxiety in the postpartum period compared with placebo.

Variable	HN001 (n = 193) mean (SD)	Placebo (n = 187) mean (SD)	Mean Difference (95% CI)	p-value	Additional Notes
Depressive symptoms (EPDS, modified version)	7,7 (5,4)	9,0 (6,0)	-1,2 (-2,3; -0,1)	0,037	-
Anxiety symptoms (STAI, modified version)	12,0 (4,0)	13,0 (4,0)	-1,0 (-1,9; -0,2)	0,014	-
Clinically significant anxiety (STAI > 15)	-	-	OR = 0,44 (0,26; 0,73)	0,002	Lower risk in the HN001 group

To conclude, available searches demonstrate the positive impact of some supplements (omega-3 fatty acids, Vitamin D3, iron, zinc, probiotics) on perinatal depression management. Nevertheless, their role in depression prevention is still not fully understood and further research is needed. Omega-3 fatty acids supplementation in dose 2 grams of EPA and DHA daily since initial gestational age caused statistically significant effect on reduction of depressive symptoms, particularly in relation to postnatal depression. Evidence on effectiveness of omega-3 fatty acids on perinatal depression prevention is limited, and the data is dependent on search population. Low level of folic acid is connected with increased risk of postnatal depression, however no effectiveness of folic acid supplementation on developing perinatal depression was confirmed. Vitamin D3 supplementation in the late stage of pregnancy and postpartum significantly decreased severity of depressive symptoms. Moreover, the positive

effect of zinc supplementation was confirmed especially among females with deficiency of that substance and anemia.
Case-control studies and meta-analyses show the presence of beneficial effects on perinatal depression prevention and treatment through iron supplementation. Other factor that proved to have a notable effect on decreasing depression and anxiety symptoms was probiotic Lactobacillus rhamnosus HN001. These findings suggest a potential role for the microbiota and probiotic supplementation in mood regulation.

2. Effect of Physical Activity on Perinatal Depression

Throughout previous years several studies describing the influence of physical activity on perinatal depression were evaluated. In November 2025 a meta-analysis discussing impact of physical activity on perinatal depression symptoms particularly in relation to subclinical depression was published. Meta-analysis was conducted in accordance with the PRISMA 2020 guidelines and the compared original articles reporting randomised controlled trials were published from 2014 to 2024. Including criteria were females over 18 years old, of any race, of any level of physical activity, during pregnancy or up to 12 months postpartum. The major exclusion criteria was diagnosed depression, because the priority of the study was to evaluate subclinical depressive symptoms such as anxiety, stress, fatigue and insomnia. Previously mentioned symptoms usually precede formal depression diagnosis and they indicate a patient's well-being. The analysis considered 9 trials conducted in various regions. The compared searches differed majorly in type of physical activity, frequency of physical activity and its intensity. Interventions included aerobic exercises such as walks, moderate intensity training and other forms of physical activity like yoga. Frequency of training in the analysed trials varied between 1 up to 5 sessions weekly, and time of a single training ranged between 20 minutes up to 60 minutes. A significant element that diversified searches was level of supervision, ranging from interventions conducted under specialist oversight to self-directed programs, and culminating in reduced supervision due to the onset of the COVID-19 pandemic. The overall effect of meta-analysis demonstrated moderate depressive symptoms reduction (SMD = −0.47; 95% CI: −0.86 to −0.08), which confirmed the validity of recommending physical activity as a strategy of mental health protection during the perinatal period. The limitation of meta-analysis is high heterogeneity (I^2 = 88%), which is associated with previously mentioned differences in methodology and clinical factors. Despite the high heterogeneity, the results are in accordance with the guidelines recommending physical activity during pregnancy and postpartum as a factor that alleviates stress, anxiety, insomnia and has other beneficial effects such as better glycemic control during pregnancy, reducing triglycerides level and shortening of labor duration (17).

In January 2026 a trial conducted in Japan in prefecture A was published. 628 females postpartum were examined in order to compare the mood fluctuations immediately after a single-session exercise program using the validated Japanese short-form Profile of Mood States (POMS). A trial focuses on acute psychological reactions to aerobic movement. It does not take under consideration other factors like for instance group support or parent-child interaction. Additionally, a distinguishing feature of the study was the climate, in which women lived because this region is known from prolonged winter season which restricts opportunity to

exercise outside. Unfavorable weather conditions hinder a walk or jogging that is why there was a necessity of planning aerobic (5-6 MET) activity in the domestic environment. Participants were asked to perform exercises using a fitness ball. Exercises majorly involved indoor bounce-based aerobic exercise and one training was composed of a warm-up, main exercises and relaxation using controlled breathing techniques. The POMS scale is divided into following subscales: tension–anxiety, depression–dejection, anger–hostility, vigor, fatigue, confusion. The questionnaire was filled in by females before and immediately after the physical activity. Comparison of results before and after aerobic physical activity showed that the most pronounced changes were visible in relation to subscale tension–anxiety and vigour, while a moderate improvement was visible in the subscale anger–hostility. In the area of depression–dejection there was no significant change. Those results demonstrate that single-session exercise improved patient's well- being immediately and short-term. However, this study can not assess long-term effects of physical activity on developing perinatal depression. Other methodological limitations are lack of information about examined patients, no control group and randomisation of the trial (18).

Table 2. The effect of physical activity on immediate changes in POMS subscales.

Subscale POMS	Before (M ± SD)	After (M ± SD)	Mean difference	t(df)	p-value
tension–anxiety	47,7 ± 8,2	39,3 ± 6,6	−7,91	−17,02	$p < 0,001$
anger–hostility	47,2 ± 7,21	43,2 ± 4,98	−4,61	−10,18	$p < 0,05$
depression–dejection	46,2 ± 7,56	45,1 ± 7,01	−0,33	−0,88	not statistically significant
vigor	47,2 ± 11,3	58,5 ± 10,17	11,82	15,88	$p < 0,001$

3. Pharmacology in perinatal depression

In 2021 Jennifer Valeska Elli Brown and colleagues carried out a meta-analysis in which effectiveness and safety of antidepressants in perinatal depression treatment compared to other types of management and placebo group was evaluated. 11 randomised clinical trials were analysed. Searches were performed majorly in high-developed English-speaking countries. Two of the searches were conducted in middle-income countries. Participants were recruited from different environments - both in primary health care, local communities, and in obstetrics departments. The vast majority focused on selective serotonin reuptake inhibitors (SSRI), and the mean time of treatment was from 4 to 12 weeks. Meta-analysis results proved that SSRI are more effective in comparison to placebo groups in the field of response to treatment, remission and decreasing depressive symptoms. The amount of searches was minor, and the index of dropouts from the trial was high, that is why the overall certainty of the evidence regarding

SSRIs was low. The effectiveness of SSRIs was not assessed compared to other medicines and alternative therapies, psychotherapy and standard care. The amount of evidence of effectiveness and safety SSRIs is insufficient, particularly if it comes to severe perinatal depression. There was only low quality evidence that SRRIs are more therapeutically useful than placebo in perinatal depression treatment. The Authors suggest that there is a necessity to perform further studies which would include more numerous participant groups, longer observation period and comparison between other forms of approach like psychotherapy and other groups of antidepressants (19).

Table 3. Effects of SSRIs Compared with Placebo on Treatment Outcomes in Depression.

Result	SSRI	Placebo	Effect size	95% CI	Interpretation
Response to treatment	55%	43%	RR = 1,27	0,97–1,66	No statistically significant effect was observed (the confidence interval includes 1), although a trend favoring SSRIs was noted.
Remission	42%	27%	RR = 1,54	0,99–2,41	The result was borderline non-significant, with a potential benefit of SSRIs.
Reduction in depressive symptoms	-	-	SMD = -0,30	-0,55 to -0,05	A statistically significant improvement, but with a small to moderate effect size.

Nowadays, there is increasing interest in faster-action perinatal depression treatments methods such as neurosteroides, ketamine and non-pharmacological approach: transcranial magnetic stimulation (TMS). Emily M Beydler and colleagues performed research titled ”Rapid-Acting Treatments for Perinatal Depression: Clinical Landscapes and Future Horizons” in order to investigate the latest perinatal depression therapies. What are more benefits and risks of using long-term methods like electroconvulsive therapy or SSRIs were discussed. Authors mentioned factors that have an influence on the choice of a specific treatment method. They suggest the necessity of considering the moment of symptoms onset, depression severity, breastfeeding,

previous treatment, response to treatment and costs and availability of the therapy. Current antidepressant treatment is recommended, however some females do not respond to those medicines, do not want to have long-term treatment or pharmacotherapy intervention. It is crucial to investigate faster-action ways of perinatal depression therapy, because untreated might lead to suicidal thoughts, preterm delivery, preeclampsia, disrupted bonding with the child and lactation difficulties.

In 2019 FDA approved new antidepressants: brexanolone and esketamine. Brexanolon is an allopregnanolone neurosteroid modulating the GABA-A receptor that is distinguished by its rapid onset of action because the effect is visible after a few days of treatment. The disadvantage of brexanolon use is the method of administration - it is delivered through sixty hours long intravenous infusion during the 72 hours hospitalisation. That is why this substance was withdrawn from the market and replaced with zuranolone - an oral synthetic allopregnanolone analogue. It acts in a similar way as GABA-A modulator, but it can be administered ambulatory once a day through 14 days. The response to the treatment among females reached approximately 60%. Zuranolone is used among patients who are initiated to present depressive symptoms between the third trimester and fourth week postpartum. During the neurosteroides therapy breastfeeding is contraindicated due to lack of studies on breastfeeding females.

Ketamine is stated to be a promising method among patients suffering from drug-resistant depression and presenting suicidal thoughts. Nevertheless, it should not be instituted during the pregnancy due to higher risk of fetal defects. There is a need to perform further examination on that topic. In China a study was conducted in order to compare postnatal depression treated with esketamine in epidural analgesia and placebo. After 42 days postpartum, the amount of severe depression episodes was 75% lower in the esketamine group in comparison to placebo. Despite the promising results, esketamine in treating perinatal depression is not included in the current guidelines.

Some females are not willing to use pharmacotherapy in perinatal depression treatment according to the presence of concerns about drug transfer across the placenta or into breast milk. That is why a growing importance of non-pharmacological management is observed, particularly those characterised by fast-action like for instance transcranial magnetic stimulation (TMS). TMS works by multiple magnetic impulses repeatedly applied to a specific region of the cerebral cortex. In depression the dorsolateral prefrontal cortex is stimulated. TMS presents promising results as a safe and acceptable during pregnancy method. No negative influence on patient's infants during the 62 months observation was noted and the side effects of TMS were mild (headache, discomfort, supine hypotension). The method which is even faster are accelerated protocols of TMS, in which a single session might last a few minutes and the visible effects are observed after a few days. A good example is the protocol SAINT (Stanford Accelerated Intelligent Neuromodulation Therapy) that lasts 5 days and is completed within 50 sessions, and the remission rate immediately after treatment and after one month was 90.5% and 60% respectively. Unfortunately, despite FDA approval, this method has a limited availability.

The other non-pharmacological method of perinatal depression treatment is electrocompulsive therapy. One of its advantages is safety in every trimester of pregnancy and it is also effective in severe drug-resistant depression. ET is also recommended when a life threat such as suicidal thoughts or acts and perinatal depression with psychosis are present.

The most commonly chosen in perinatal depression treatment are SSRIs. However, due to the slow onset of SSRIs - recovery is reached usually after 2-4 weeks and the full efficacy is achieved after 6 to 8 weeks- it is necessary to evaluate new methods of management. Another SSRI advantage is its lack of impact on congenital malformations. SSRI remains one of the most frequently chosen treatment methods among pregnant patients, particularly among females before the third trimester or after four weeks postpartum, who can not be treated with zuranolone (20).

Conclusion:

The above literature review demonstrated that lifestyle factors, such as supplementation and physical activity influence the severity of perinatal depression symptoms. The improvement is particularly connected to development of the overall mental well-being of women.

Studies related to supplementation show that particularly promising results were gained in relation to vitamin D and probiotics that affect hormonal regulation and the gut-brain axis. The role of other supplements: omega 3-fatty acids, folic acid, iron and zinc remains unclear and there is insufficient evidence to support their use as a preventive measure for perinatal depression.

Physical activity presents a moderate impact on depressive symptoms reduction. Consistent physical activity contributes to decrease in severity of subclinical symptoms such as: anxiety, level of stress or sleep quality. What is more, even one-time aerobic exercise immediately improves a patient's well-being.

The review demonstrated an analysis of pharmacological approach considering currently first-choice treatment - SSRI but also new management methods including neurosteroides, ketamine and transcranial magnetic stimulation (TMS). According to searches SSRI is characterized by moderate symptom reductions efficacy in comparison to placebo group. There is a need for further research on new treatment methods to assess their long-term safety and efficacy

Described lifestyle factors may account for significant adjunct to standard perinatal depression therapy, however it is worth noting that treatment should be multimodal depending on the severity of symptoms and the patient’s clinical condition. Lifestyle modification composed of supplementation or physical activity can support perinatal treatment.

Disclosure

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Funding Statement:
This research received no external funding.

Institutional Review Board Statement:
Not applicable

Informed Consent Statement:
Not applicable

Data Availability Statement:
Not applicable

Acknowledgements:
Not applicable

Conflict of Interests Statements:
The authors declare no conflict of interest.

Declaration on the use of AI
In preparing this manuscript, the authors used ChatGPT for language improvement and enhancing readability. Following the use of this tool, all content was reviewed and edited by the authors, who take full responsibility for the accuracy and integrity of the final version.

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