Mental health conditions in pregnancy and what should you do?

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Clinical vignette
Optimal care

- Identified PH serious psychiatric illness.
- Identified FH of mental illness.
- Communication between GP and midwife.
- Referral to psychiatrist in pregnancy so that risk management plan could be made.
Outcome

• Admission may still have been necessary.
• Less surprise and trauma.
• No further pregnancy.
Link between childbirth and mental illness

• Described since middle ages.
• Marce treatise mid 19th century.
• Kendall 1987 increase admissions post partum.
• CEMD UK since 1997
Confidential Enquiry into Maternal Deaths UK (CEMD)

- Psychiatric disorders and suicide in particular leading cause of maternal death.
- Majority of women who committed suicide had severe mental illness.
- Half had been treated by psychiatric services in that pregnancy.
- Half had a past history of admission to a psychiatric unit.
Confirmed increased rates of affective psychosis in the post partum period.

Women who died by suicide did so violently indicating serious mental illness.

Older more socially advantaged than other maternal deaths.

Illnesses had rapidly deteriorating course.

Most post natal recurrence of existing disorder.
Why do we need to know about psychiatric disorders in pregnancy...?

Because...

• ... they are the commonest complication of childbirth.

• ... they are the leading cause of death in the first post partum year (CEMD).

• ... even when recorded there is a high risk of inadequate antenatal care.

• ... risk of relapse is high for some disorders and comes with a long warning period.
Psychiatric disorders and pregnancy

• Psychiatric illness can be precipitated by pregnancy and childbirth, both new disorders and recurrence.

• Pregnancy can effect existing psychiatric disorders.

• Psychiatric disorder can have an effect on the obstetric course and ultimately the baby.
Mood disorders

- Mood disorders are common in pregnancy.
- Peak during third trimester.
- About 10% depressed mood.
- Risk factors similar to non pregnant women.
- Younger, socially disadvantaged, low SE group, more children.
- Overall high risk development of mood disorder.
Recognition of depression in pregnancy

- Belief that pregnancy is a happy time.
- Sx in late pregnancy similar to depression.
New affective disorders

Blues

Post Natal Depression

Puerperal Psychosis
Post Natal Depression

- Onset up to 6-months post partum.
- Can last from weeks to even years.
- Usual Sx of depression.
- Treatment anti depressants and psychotherapy CBT.
- Incidence around 15%
Depression

- DEPRESSED MOOD or
- LOSS INTEREST OR PLEASURE plus
- Appetite change
- Insomnia or hypersomnia
- Psychomotor agitation or retardation
- Loss energy or fatigue
- Worthlessness or guilt
- Diminished ability to think or concentrate
- Recurrent thoughts death, suicidal ideas or plan
- Used to be thought atypical.
Risk factors for PND

- 50% depressed in last trimester.
- Past psychiatric history of depression.
- Poor partner support.
- Negative life events.
Importance

• High morbidity.
• Far reaching effects on woman, infant and family.
Management

- Mostly managed in Primary Care
- EPDS valuable screening tool.
- Remember PTSD post partum
- Social support really important
- Encourage use of support group
- Psychological treatment CBT IPT
- Antidepressants if moderate or severe
- Use psychiatric services for consultation
High risk

Psychiatric referral if...

• Suicidal
• Bipolar depression suspected
• Psychotic
• Early onset post natal with elevation
• Psychomotor agitation/retardation
• FH bipolar disorder
• PTSD
Puerperal psychosis

- Onset first 2/52 post partum up to 3/12
- Psychiatric emergency
- Last weeks to months
- Severe affective, schizophreniform and confusion
- Incidence 3:1000
- Treatment includes medication and admission
- ECT
Symptoms include:

- Delusions, hallucinations, perplexity and confusion.
- Sleeplessness is often an early symptom.
- It is NOT normal to have difficulty sleeping post partum.
Prognosis

- Bipolar disorder with childbirth as specific trigger
- Sudden onset, rapid deterioration
- 50% puerperal recurrence
- 60% non-puerperal recurrence FH important
Recurrence post partum

- Bipolar disorder
- High rate relapse 70%
- Considerable warning time
- Sudden onset
- Rapid deterioration
- Well in pregnancy
- Mood stabilisers may have been stopped.
Bipolar disorder

“I’m right there in the room, and no one even acknowledges me.”

The New Yorker, 9/18/06
All women with a Hx of severe mental illness should be seen by a psychiatrist in pregnancy so that a management plan can be made prior to delivery and shared with the woman and her family.
Existing psychiatric disorders

- Puerperal Psychosis
- Bipolar Disorder
- Schizophrenia
- Severe Depression (Psychotic & Non-Psychotic)
- Schizoaffective Disorder
Effect of pregnancy on existing psychiatric disorder

- Bipolar disorder risk depressive relapse in pregnancy and very high risk mania post natal.
- Schizophrenia relapse usually caused by stopping medication.
- No worsening schizophrenia postpartum but parenting a concern.
- Depression up to 50% relapse rate in pregnancy.
Effect illness on obstetric course

- Concern about effect of psychototropic medications on foetus from women and health professionals.
- Medications are sometimes stopped suddenly with devastating effects on women and her family.
- All decisions to continue are risk/benefit.
- Discussion re pregnancy should occur with all women of childbearing age.
• Babies of women with schizophrenia have higher rates congenital abnormality.

• Increasing evidence that anxiety and depression in pregnancy can have long lasting adverse effects on child development.

• Intimate partner stress may be important.

• Some evidence that emotional support improves outcome.
Poor obstetric outcome

Severe mental illness is associated with…

• Smoking
• Substance abuse
• Alcohol use
• Poor nutrition
• Socio economic disadvantage
• Pre term delivery
Late booking

Is a red flag for...

• Psychiatric problems
• Domestic violence
• Drugs/Alcohol
• Care and Protection Services
• POOR Obstetric Outcome!
Impact on infants

• Complex and inter-related
• Infants’ relationship with primary caregiver of great importance.
• Mental illness in parent can affect almost all aspects of child development.
• Separation traumatic for mother and baby.
• Infanticide rare but significant risk of severe psychosis usually depressive.
Importance of communication

- LMCs need to ask about PPH and FH
- Communicates importance. Reduces stigma.
- LMC and GP need to pass on important information.
- Psychiatrist and women of child bearing age when prescribing.
- Women sometimes fear the answers and so don’t ask.
What happened to Sophie?

- Psychiatric care not optimal.
- Admission without baby.
- Bonding disrupted.
- Breastfeeding stopped.
- Lost confidence and disempowered on return home.
- Family distressed.
- Traumatised by hospitalisation.
- Fully recovered at 12-months post partum.
Pregnancy and psychiatric disorder

- 6 Women in 1000 who deliver will be seriously mentally ill, most with affective disorders.
- Many require psychiatric admission.
- 60,000 deliveries last year.
- Advocate for Mother/Baby unit in North Island.
- There are many Sophies in New Zealand.
Mental ILLNESS in pregnancy
and what should WE do?