

# Mental health conditions in pregnancy and what should you do?

Dr Cathy Hapgood  
Psychiatrist  
Waitemata DHB

# 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 19<sup>th</sup> 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.

# CEMD

- 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

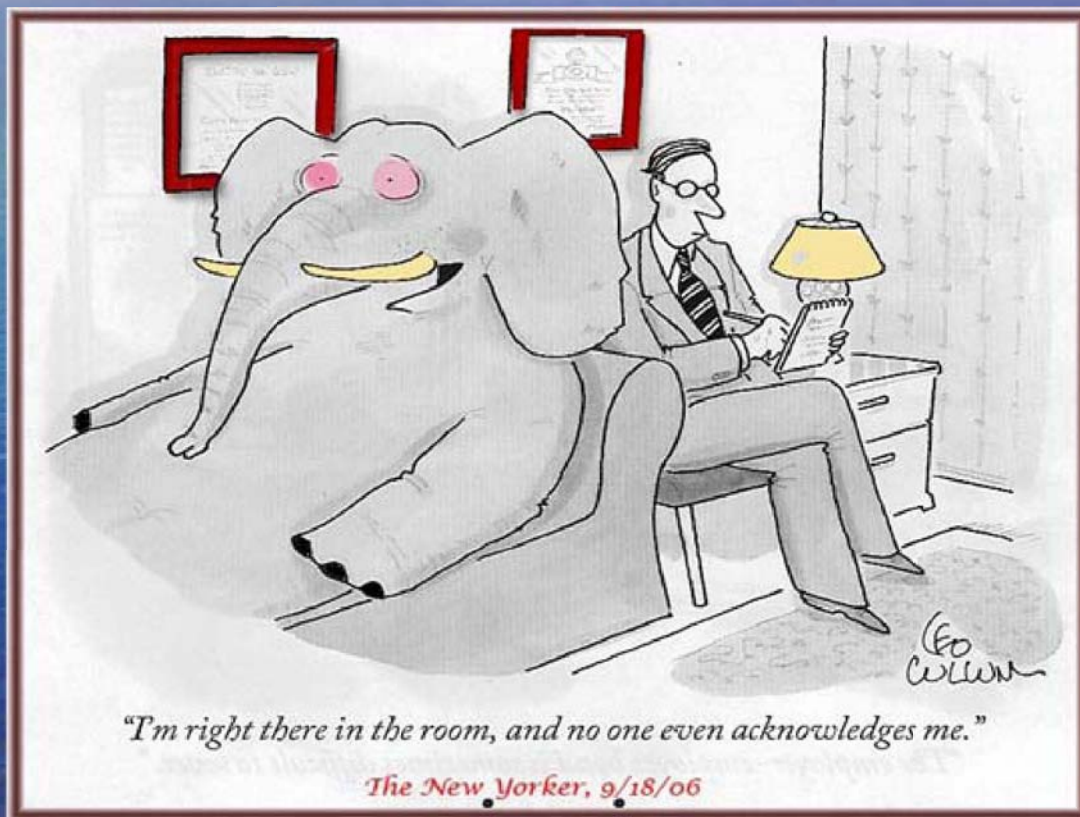
# Prognosis

- 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



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 psychotropic 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.

[www.mothersmatter.co.nz](http://www.mothersmatter.co.nz)



# 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.
- Traumatized 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?