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Motherhood and mental illness

Part 1 – toward a general understanding

Background

Mental illness is common among women of childbearing age, and fertility rates of women with mental illness are close to those of the general population. General practitioners will see most of the women who may be seeking advice and management of their mental illnesses before, during or after a pregnancy.

Objective

This article reviews the current approaches to the management of mental illness in and around pregnancy, and provides practical advice regarding pregnancy related issues in women with mental health disorders.

Discussion

The GP is ideally placed to give information and encourage appropriate treatment choices in women with mental illness. Given the multifaceted complexities, the optimal approach is holistic and collaborative. Specialist opinion must be sought early and a multidisciplinary approach with access to specialist care offered if possible. Continuity of care, especially in the context of a trusting therapeutic relationship, is considered optimal.

■ **Although pregnancy and childbirth can be a time of great joy, for some women and their families it may also be a time of turmoil. While the prevalence of serious mental illness such as schizophrenia remains low, it is estimated that up to one in 5 women will experience clinically diagnosable depression or anxiety during pregnancy and the postpartum period.¹ Many of these women may be taking medications, and this may be a cause of anxiety for both the patient and their physician. While issues regarding the pros and cons of medication to mother and fetus are important, there are many other factors impacting on maternal, fetal and infant wellbeing that need to be considered.**

Women with chronic mental disorders are at high risk for pregnancy and birth complications.² The ultimate goals for these women are to:

- improve obstetric and neonatal outcomes
- provide timely intervention for prevention of serious sequelae
- improve quality of care
- determine if adequate social support is being provided, and
- implement and maintain both nonpharmacological and pharmacological management strategies.

Recognition of depression

Many women fail to identify themselves as being depressed or fail to seek help;³ and due to a number of reasons, many health professionals may not recognise depression or anxiety in the pregnant or postpartum women, often passing it off as 'adjustment' issues. *Table 1* lists factors that are indicators of risk of mental illness in women during pregnancy and the postnatal period. The Edinburgh Postnatal Depression Scale (EPDS)⁴ is a useful screening tool – which has been translated into many languages – that can aid the health care professional in quantifying symptoms of depression and provides a template for referral. It is also important to recognise that the course of depression and anxiety can change during the pregnancy,⁵ and in the last trimester, depression can be particularly difficult to recognise due to the overlap of somatic symptoms of depression with late stage pregnancy changes.

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In the postpartum period there are common themes that can aid the clinician in recognising postnatal depression (PND)⁶:

- incongruence between the expected experience and that which occurred (this may be either a symptom or a contribution to the aetiology)
- spiralling downward (feeling overwhelmed, anxiety and anger, obsessive thinking)
- pervasive loss (especially loss of former identity), a type of disavowed grief.

Pre- and post-conception counselling

A collaborative approach to management is essential. The importance of preconception counselling is crucial but often opportunistic. The window of opportunity may be missed by an unplanned pregnancy or late presentation. Even if the 'horse has bolted', postconception counselling can be beneficial. A pre- or post-conception planning discussion needs to focus on both specific mental health issues and routine pregnancy issues (*Table 2*).

Women with chronic mental illness have higher rates of sexually transmissible infections.⁷ They may have more sexual partners, engage in high risk sexual practices, or be victims of abuse.⁸ It is important to screen both early in the pregnancy and, if at continued risk, in the third trimester.

A thorough risk-benefit analysis is essential regarding medication. Many women with mental health problems may be taking some form of medication and this may be a cause of anxiety. It is not surprising therefore, that, either because of their own fears or on the advice of others, some women abruptly discontinue their medication when they discover they are pregnant. There is ample evidence showing increased rates of relapse for women who discontinue treatment during pregnancy.^{9,10}

A more concerning issue is that untreated or inadequately treated depression and anxiety not only negatively affects the pregnancy and the delivery, but also the neurodevelopment of the fetus,^{11,12} which, when combined with potential attachment disruption in the postpartum, can have synergistic and far reaching consequences. The risks associated with some medications, such as antipsychotics, remain uncertain as relatively little information is available at present.¹³

The main aim of preconception counselling is to present all the information available so an informed decision can be made. (Part 2 of this article provides further more specific information in regards to medications.)

When there is a history of severe mental illness such as a past history of psychosis or psychiatric hospitalisation, or multiple

Table 1. Indicators of risk of mental illness¹⁸

- History of poor compliance with appointments and/or medication
- Not attending for appropriate antenatal investigations/postnatal care
- Not monitoring own health and nutritional status appropriately
- Unable to sleep – unrelated to baby waking
- Tendency to resort to cigarettes, alcohol and other drugs to relieve stress
- The victim of intimidation and/or violence from a partner
- Difficulty relating positively to her fetus and infant
- Reckless, self harming or suicidal behaviour

Table 2. Relevant history for management plan

Specific mental health history

- History of past mental illness and treatment including hospitalisation
- Family history of mental illness
- Recent progress and current mental state including self harm risk
- Support network
- Current medication; the role of medication such as antipsychotics in infertility, their known safety data during pregnancy and lactation
- Fears (eg. medication, inherited risks, effects of pregnancy on work and relationships)

Normal pregnancy related issues

- Drug use past and present
- Smoking and alcohol consumption
- Diet and nutrition
- Supplementation (eg. folate 5 mg needs to be considered, especially with certain medications such as anticonvulsants)
- Understanding of antenatal investigations, including first trimester screening and anatomy scan
- Sexually transmissible infection screening
- Past general medical history and risks

medications and complex health care needs, early specialist involvement is indicated. In these vulnerable women, it is important to maintain consistency and continuity of care with close liaison between obstetric, mental health services and the general practitioner.

Psychological adjustment to pregnancy

Pregnancy is a time of profound psychological changes. The common adage of 'when a child is born, a mother is also born' highlights the challenge for women to adapt to their changing role. Some women have a tendency to idealise the pregnancy and parenthood, and this can lead to disillusionment should reality fall short of expectation. Pregnancy is also a time of reactivation of past anxieties, traumas and disappointments, including a re-evaluation of the quality of parenting that the woman and/or her partner experienced themselves. All these

issues may need to be addressed with referral to a psychologist as appropriate.

It is important, if possible, to bring the partner into the consultation early and include them in the risk-benefit discussion regarding treatment options. They can be actively enlisted to be supportive and help their pregnant partner to comply with treatment. They are also often in a position to monitor for early indicators of relapse. The partner themselves can often be at risk, and if the woman is depressed, the partner's risk for depression is increased from 4.8 to 36% at 6 weeks postnatally.¹⁴

Crisis presentations

Often due to the nature of mental illnesses and their secondary sequelae, women may present in crisis with late discovery of pregnancy. This increases the difficulty of management. It is important therefore to ensure adequate systems are in place for monitoring and continuity of care in all women of childbearing age, with regular discussions of contraception and family planning.

Other drugs

The rate of smoking and alcohol consumption may be increased in this group of women, as well as other substance abuse, and patients will need to be counselled appropriately or linked in to specialist services.

Social issues

An understanding that poor social supports, an abusive and violent partner, and accommodation difficulties may all precipitate and perpetuate psychiatric disorders. This group of women may have poor access to an adequate standard of housing, or be homeless or frequently mobile in their accommodation, and it is important to monitor and offer support in this regard. If appropriate, it may be worth enlisting family or community case worker support in antenatal and postpartum care.

Special populations

Indigenous patients and those from culturally and linguistically diverse backgrounds are particularly vulnerable to the development of perinatal mental illness. Their presentations are often complex, with an interplay of depression, anxiety, trauma and victimisation, and acculturation difficulties as well as social deprivation.

Working with indigenous families of high burden and trauma can be challenging, and health professionals need to maintain good self care and a sense of hope to avoid feeling overwhelmed.¹⁵

Preparation for the birth

In addition to encouraging women and their partner to take an active part in antenatal classes and providing individual education on a one-on-one basis as required, several special considerations need to be considered.

First, if practical, organise a guided tour of the delivery suite in the third trimester. This offers the woman and her partner the opportunity

to become familiar with the surroundings and staff, given the chaotic and anxiety provoking nature of the delivery process.

Second, pain control management may be important given the interaction between anxiety and pain. Pain relief during labour is a complex issue for all women, and special consideration should be made for women who have mental illness. It is important to discuss all pain management options with the woman and her partner, taking into account her likely mental state during delivery, her psychotropic medication, and the likelihood of compliance with labour and delivery procedures. Adequate analgesia, such as with an early epidural, may be beneficial in decreasing anxiety and increase coping ability early after delivery. Patient controlled epidurals can also allow these women a sense of control during their labour. A supportive environment, including the use of nonpharmacological techniques such as massage, breathing, imagery and positive support, are also useful methods for reducing anxiety and decreasing pain perception.

The postpartum period

The key to management in this crucial period is planning and early intervention. Increased observation must occur for both mother and baby. In many cultures, childbirth brings forth a mobilisation of supports from the extended family, which may modulate psychiatric morbidity.

It has been shown that women suffering from depression are more likely to have impaired attachment with their child.¹⁶ Attachment, which some writers liken to a pathway to the development of a 'psychological immune system',¹⁷ is a co-regulating relationship between the child and their primary care giver (often the mother) that underpins the child's socio-emotional development. How a person learns to regulate their emotions and relates to themselves and others depends very much on their relationship with their primary care giver in the first years of life, a relationship that can be disrupted by mental illness.

Many women with mental illness are unsuitable for early discharge from hospital after giving birth. A short period of hospitalisation may help with observation of mental state and raise awareness of parenting and attachment issues. Some women may benefit from referral to a mother-baby unit for additional support. Early intervention strategies involving the child health nurse may be beneficial for those at risk.

The GP is often required to carry out a 6 week postpartum check on both mother and baby. Women at high risk should be encouraged to see their local GP earlier and be reviewed at 3 weeks and 6 weeks. This would allow increased monitoring of early warning signs, compliance with medication, ability to cope with parenting role, sleep patterns and social supports.

Conclusion

Confronting complex and interacting issues in working with women who have mental illness before, during and after pregnancy, can be difficult. However, failing to address these issues is likely to have significant negative consequences for both mother and baby. In all cases, vigilance and collaborative discussion with the patient,

their family and specialist services would be considered best practice. For the GP, the key components to working successfully with this group of challenging women are early intervention, planning and coordination.

Conflict of interest: none declared.

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