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Perinatal mental health

Identifying problems and managing medications

Background

Perinatal psychiatry has expanded from the traditional focus on mental health in the postpartum period to include a greater understanding that women may become unwell during pregnancy and that the risks to the infant from exposure to illness start before birth. One of the key roles for the general practitioner is to help women with known mental health issues to prepare for pregnancy, as well as identify those at risk and help to guide management choices.

Objective

This article reviews the issues to consider when managing perinatal illness, focusing on medication.

Discussion

Perinatal mental illness is common. The illness poses a risk to mother and child through treating and not treating. The aim is to identify risks early, manage them assertively but sensitively, and ensure that the mother is as well as possible while minimising risk to the child.

Keywords

mental disorders; perinatal care; psychotropic drugs

CPD

Historically, the focus when considering mental health issues associated with childbirth was on the postpartum period. Perinatal psychiatry has now expanded to include a greater understanding that many women become unwell during pregnancy, that depression and anxiety are often intertwined, and that the risks to the infant from illness exposure start in pregnancy. Knowledge is power but given the magnitude of research, trying to make sense of available evidence is hard for the perinatal specialist, harder again for general practitioners (GPs) and women who may not have clear, sensible help in understanding their choices. One of the key roles for GPs is to help women with a history of mental illness prepare for pregnancy. They should also be able to identify women at risk or who develop illnesses, and help them make choices about management.

Anxiety and depression in late pregnancy and the postpartum period are common: the beyondblue postnatal depression screening program that looked at women across Australia found it affected around 16% of women.[1] The Federal government has introduced routine screening, implemented variably across the country, which will identify many women who may have a mood or anxiety disorder. However, GPs need to make the diagnosis and identify those at risk.

Key risk factors

Risk factors for perinatal mental illness[2–5] are listed in *Table 1*. The Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM V),[6] like DSM IV, does not recognise perinatal illness as separate apart from as an onset criteria. Common diagnoses that need to be considered perinatally include major depression, adjustment disorder, post-traumatic stress disorder, panic disorder, generalised anxiety disorder and obsessive-compulsive disorder. First episodes of bipolar affective disorder or schizophreniform psychosis (the former more common) need consideration in postpartum psychotic presentations. For women with a history of schizophrenia, bipolar and borderline personality, the illnesses may affect the capacity to safely parent and these patients need to be managed with this in mind.

Table 1. Risk factors for perinatal mental illness[2–5]

History of psychiatric illness*
Family history of affective and anxiety disorders*
Isolation or low level of supports* for the mother and partner (including intimate partner violence.)
Numerous stresses*
Childhood abuse (any)/insecure or disorganised attachment
Low education/low socioeconomic
Perfectionistic personality style
*high level of supporting evidence

Barriers and challenges

A high score on an Edinburgh Postnatal Depression Scale[7] does not mean that the woman has a psychiatric illness. Nor does it mean, even if it is recommended, that she will present for treatment. It does, however, raise a possibility that she might benefit from help. The stigma of depression, as well as being labelled a failure and a bad mother, are still strong disincentives for women to acknowledge that they might be at risk or need help. Although awareness campaigns help, some women still struggle to recognise that they might be depressed, particularly when the pregnancy has been planned and the baby is wanted and loved.[8] Aversion to taking medication, especially when pregnant or breastfeeding, adds to the reluctance to seek help. Part of this is fear based on lack of knowledge, but these women ask to be listened to first, and a too rapid resort to a prescription is likely to disrupt or rupture the therapeutic alliance.[8] Education and implementation of social supports may be better first steps and medication reserved as a next-step option, allowing women to reflect and ask questions before committing to drug treatment. For some women, it is a baby-related crisis that gets them attention; when the baby is deemed well, then the focus can turn to how the mother is coping.

Risk issues for mothers and their children

Unlike mental illness at other times of life, perinatal illness affects the child directly and indirectly. Research shows clearly that during pregnancy maternal anxiety exposes the child to higher levels of cortisol, which continues to be present at higher levels throughout the child's life and may well be a marker for the higher rates of anxiety, and mood and behavioural disorders seen in these children. The rates are highest when the mother is unwell throughout the perinatal period, but next most significant if the exposure is antenatal, ahead of postnatal exposure (only) to maternal mental ill health.[9]

Women who are mentally unwell during pregnancy are less likely to care for themselves, are at risk of suicide and self-harm, are more likely to use alcohol and illicit drugs, and have higher rates of intervention, complications and infants requiring intensive care with and without medication.[10,11] Postnatal mental illness increases the risk of neglect and attachment difficulties.[12]

Not treating (or treating with psychological methods alone) needs to be balanced against the risks of medications used during pregnancy and lactation. Guidelines and up-to-date information are available through the internet or by telephone.[13,14] It is important to remember that there are no randomised controlled trials in pregnancy and factors such as the use of multiple medications and alcohol consumption are often significant confounding variables that are not always taken into account in the analyses of available studies. Broadly, treatment considerations can be divided into four categories: teratogenicity, second–third trimester, neurobehavioural and withdrawal/toxicity (*Table 2*). These are of primary importance in pregnancy. In lactation the only psychotropics considered to be absolutely contraindicated are lithium and clozapine, and exposure is usually far less.[15] Of the antidepressants, more is known about the selective serotonin reuptake inhibitors (SSRIs) than the serotonin-norepinephrine reuptake inhibitors (SNRIs), and levels in breast milk may be a little higher with cipramil and venlafaxine.[16,17] Babies should be monitored for side effects and to ensure they are not sedated and their weight gain is normal.[15]

Medication: getting the balance right

There is no right or easy answer on how to manage mental illness in pregnancy. In each case the woman and her partner need to weigh up the risk–benefit ratio with the help of health professionals. A second opinion may be useful. Explanations from health professionals should be documented and a copy given to the patient. The aim is to keep the woman as well as possible while keeping the risk to the child at a minimum. Ideally, the woman should be well and stable for at least a year before conception, but this may be impractical, particularly if the woman is older. Stress should be excluded as far as possible, with a healthy lifestyle as pertaining to diet, exercise, sleep, ceasing smoking and minimising alcohol, and folate commenced.

If a woman has a history of suicide attempts and hospital admissions, or has bipolar disorder and a family history of the same, it is inadvisable to try no medication. For women who are less severely unwell and who cease medication, a clear plan to review and look for early warning signs, and a plan including medication should they have a relapse, is needed. Even if they do not relapse, in most cases recommencing a mood stabiliser postpartum is advisable and very close monitoring and sleep hygiene essential. Mood stabilisers need to be monitored closely and are discussed elsewhere.[18] Olanzapine and quetiapine may be good alternatives to traditional mood stabilisers in pregnancy with less apparent teratogenic risk,[14] but no option is risk free in pregnancy and lactation.

General principles that should be followed during pregnancy and lactation include using the lowest possible dose and a minimum number of different medications. Previous medications that have been effective can also help to guide choices, avoiding those that are teratogenic. GPs should ensure that they liaise with their patient's psychiatrist, obstetrician and, if necessary, a paediatrician.

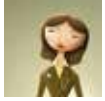

Table 2. Considerations for use of medications in pregnancy[11,18,20–26]

Teratogenicity	**Mood stabilisers[15,18,20]** Anticonvulsants • up to 17% serious malformation with sodium valproate; increased risk (up to 5%) with all others Lithium • 0.05% absolute risk of cardiac malformation **Antidepressants[11,15,20]** • no consistent, repeated findings but with most data on SSRIs, less on SNRIs **Antipsychotics[14,20]** • less information available • clozapine considered high risk (limited pregnancy data but contraindicated in breastfeeding)
Second–third trimester	**Antidepressants[11,20,22,23]** • persistent pulmonary hypertension in newborn (up to 3 per 1000 versus 1.2 per 1000 absolute risk; reversible, some studies do not show it) • pregnancy hypertension (odds ratio 1.5)
Neurobehavioural	**Mood stabilisers[15,18,20]** Sodium valproate • adversely affects IQ **Antidepressants[11,15,20,24–26]** • increased risk of developmental delays (fine motor) with SSRIs • autism (up to 2-fold increase but may be genetically based) **Antipsychotics[14,20]** • developmental delays possible but still being investigated
Withdrawal/ toxicity	**Mood stabilisers[15,18,20]** Lithium • newborn babies may be blue and hypotonic • specialised management required **Antidepressants[11,15,20,25]** Effects in up to 30% of babies (worst with venlaxafine) • slight prematurity; small for dates • respiratory difficulties • sleep disturbance • increased risk of time in neonatal intensive care **Antipsychotics[14,20]** • metabolic instability • larger babies

Women with less severe mood and anxiety disorders may benefit from cognitive behavioural and mindfulness therapies alone or in combination with medication. Those with underlying generational attachment issues need additional therapy to address this, with programs such as Circle of Security.[19]

Conclusions

Perinatal mental illness is common, and those with risk factors should be monitored closely throughout for early signs of mental illness. The illness poses a risk to mother and child, through treating and not treating; the aim is to identify risks early, manage assertively but sensitively and ensure that the mother is as well as possible while minimising risk to the child. Treating the illness itself may not be enough to reduce risks to the child where there are underlying issues, which need addressing separately.

Key points

- Maternal illness and exposure to medication during pregnancy and lactation may confer some risk to the infant; this needs to be fully discussed and documented.
- Aim to keep the mother well; if medication is needed avoid teratogens, minimise dosage and the number of agents
- Monitor closely and liaise with relevant health professionals around delivery and early postpartum for those that have withdrawal/toxicity issues and a high risk of relapse

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