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Perinatal psychiatry

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Abstract

Perinatal psychiatric disorders are common and can result in significant suffering for women and their families; indeed, suicide is a leading cause of maternal death. The most severe form of postpartum mood disorder – postpartum psychosis – follows approximately 1 in 1000 deliveries. Women with a history of bipolar disorder or who have suffered a previous severe postpartum episode are at a many hundred-fold increased risk, and their identification in the antenatal period is a key aspect of management. Decisions regarding the use of psychotropic medication in pregnancy must be made following a full risk–benefit analysis. Risks of taking many medications remain unknown but include teratogenic effects, withdrawal or toxic symptoms in the newborn and long-term developmental effects. However, these must be balanced against the risks of untreated mental illness and the risk of recurrence from stopping or switching well-established and efficacious medications. More data are clearly needed to inform the difficult choices regarding medication that women with severe mental illness are forced to make in regard to pregnancy.

Keywords

Perinatal; postnatal depression; postpartum; postpartum psychosis; puerperal

Key points

- Mood disorders in relation to childbirth are common, can result in significant suffering for a woman and her family and, in tragic circumstances, can be fatal
- Women with a history of bipolar disorder or a previous severe postpartum episode are at a considerably increased risk of an episode of postpartum psychosis
- It is important that women at high risk are identified and closely supervised through pregnancy and the postpartum period
- Decisions about medication in pregnancy and breastfeeding must be made in the context of a full risk–benefit analysis that takes into account the risks of both untreated mental illness and exposing the fetus or baby to medication

Introduction

Perinatal psychiatry refers to mental illnesses and their prevention and treatment during pregnancy and the postnatal period (up to 1 year after childbirth). It concerns far more than 'postnatal depression'. A wide variety of psychiatric disorders occur in relationship to parturition, including anxiety disorders, chronic psychoses such as schizophrenia, eating disorders and substance misuse. Anxiety and depression are under-recognized in the perinatal period. Pregnancy impacts on each of these conditions, and they, in turn, can have a significant effect on antenatal and postnatal care, with potential adverse effects on the mother, the fetus or child and the wider family.

This article focuses on perinatal mood episodes in general and on postpartum (puerperal) psychosis in particular. Although perinatal affective disorders may be associated with less stigma than episodes unrelated to childbirth, many women are still reluctant to seek help at this time, expressing concerns about being seen as a bad mother or even fearing their children might be removed from their care.

Clinical features of perinatal mood disorders (Table 1)

'Baby blues'

Over 50% of women experience a brief episode of minor mood change in the first postpartum week. The baby or maternity blues are self-limiting, last no more than a few days, do not require treatment and should not be considered a 'disorder'.

Postnatal depression

Significant depressive symptoms occur after >10% of deliveries and can last for months or even years. Episodes of major depression at this time can cause significant impairment and lead to severe long-term consequences. The symptoms of postnatal depression are the same as those of depression in other settings.

Postpartum psychosis

The most severe forms of postpartum mood disorder have traditionally been labelled as puerperal (or postpartum) psychosis. Although the boundaries of the concept are not easy to define, the core concept is of the acute onset of a manic or affective psychosis with onset in the immediate postpartum period and occurring after approximately 1 in 1000 deliveries. Symptoms are of severe affective psychosis with delusions and hallucinations. Mixed episodes, in which both manic and depressive symptoms occur simultaneously, are common, and the clinical picture is often constantly changing ('kaleidoscopic').

Aetiology

The transition to motherhood involves complex biological, psychological and social changes, and factors at all these levels are likely to play a role in the aetiology of perinatal mood disorders. Whereas psychological and social factors are clearly very important in episodes of mild to moderate severity, for severe episodes such as puerperal psychosis, it is likely that biological factors play a key role. The large hormonal changes that follow delivery and immunological¹ and genetic factors² have been found to influence vulnerability to the triggering of episodes by childbirth.

Prognosis

Postpartum psychosis has an excellent prognosis, with full recovery from the acute episode to be expected. Having suffered an episode of postpartum psychosis, however, women remain at >50% risk of a further episode of postpartum psychosis following future deliveries and an equivalently high risk of a severe episode of mood disorder unrelated to childbirth. For women with bipolar disorder, there is also an approximate risk of 40–50% of experiencing any mood episode in the perinatal period.³

Management

Although there is a limited evidence base (pregnancy and breastfeeding are frequently exclusion criteria in treatment studies), perinatal mood disorders respond to the same pharmacological and psychotherapeutic management as episodes occurring at other times. This assumption is behind many of the recommendations of the National Institute for Health and Care Excellence (NICE) guidelines on antenatal and postnatal mental health (Table 2).⁴ The perinatal context is, however, an important issue in

managing women at this time, with the baby being a key consideration both during pregnancy and in the postpartum period.

While it is not possible in an article of this length to consider the reproductive safety of individual drugs in detail, for many medications used to manage mood disorders there are concerns regarding use in pregnancy and breastfeeding, including teratogenic and short- and long-term effects on the child. Guidelines from NICE and the British Association of Psychopharmacology recommend that sodium valproate should not be used in women of reproductive potential,⁴ and there are concerns about a number of other medications used in the management of mood disorders; this is clearly an area where more data are required.

Any decision with regard to the use of medication in pregnancy must be made in light of a full risk–benefit analysis that takes account of the potential risks from not only exposure to the drug, but also untreated mental illness, which itself has adverse consequences for both mother and baby. In particular, studies have shown that stopping or switching established medication can result in a significantly greater risk of recurrence for women with unipolar and bipolar mood disorders who become pregnant, and this must be factored into the decision that is made. The knee-jerk reaction of stopping all medication in women contemplating pregnancy or finding they are pregnant is unlikely to be helpful; clinicians should help women make decisions about continuing or stopping medication based on a consideration of all possible options.

For breastfeeding women, a similar risk–benefit analysis is required, and the baby’s condition must be monitored if medication is used. When deciding which medication to use, it is important to consider a woman’s history of response in addition to data on the transfer of medication into breast milk. It is also very important to consider the baby’s general health as premature or systemically unwell infants can be at higher risk of problems. Although the evidence base for the use of electroconvulsive therapy for postpartum mood disorders is lacking, there are anecdotal reports of its effectiveness and it may need to be considered during severe episodes of illness.

Data on the reproductive safety of particular medications are constantly changing, and it is therefore sensible to obtain specialist advice on individual cases, preferably from a perinatal psychiatry specialist.

Identifying women at high risk

A key area of management is identifying in the antenatal period those women at very high risk of a severe postpartum episode. At the woman’s first contact with services, it is recommended to ask about any past or present severe mental illness, previous or current treatment and severe postpartum mental illness in a first-degree relative. History of psychopathology and psychosocial adversities, including low social support and abuse, are predictors of mental disorders in the perinatal period but have little diagnostic specificity. However, severe illness in the perinatal period is best predicted by past psychiatric history (such as bipolar I disorder or postpartum psychosis) or first-degree relatives with those disorders.

Confidential Enquiries have highlighted the importance of suicide as a leading cause of maternal death. Many women who killed themselves suffered the acute onset of a postpartum psychosis but factors putting them in a high-risk group were not identified in pregnancy and there was no clear management plan in place, highlighting the need for assertive follow-up and treatment of those in contact with psychiatric services.

It is clear that women with a previous episode of postpartum psychosis and women with a previous episode of bipolar disorder are at a many hundred-fold risk compared with the general population ([Figure 1](#)).⁵ NICE recommends that pathways be developed in all antenatal services enabling women at high risk to be identified and referred to secondary mental health services (preferably a specialist perinatal service) for assessment and treatment.

Table 2
Summary of NICE guidelines on antenatal and postnatal mental health

Women of childbearing potential

Discuss:

- The use of contraception and any plans for pregnancy
- How pregnancy and childbirth might affect a mental health problem and risk of relapse
- How a mental health problem and its treatment might affect the woman, the fetus, the baby and parenting

Do not offer valproate for acute or long-term treatment.

Pregnancy and the postnatal period

Develop an integrated care plan that sets out:

- The care and treatment for the mental health problem
- The roles of all healthcare professionals, including who is responsible for: coordinating, monitoring, providing the interventions and agreeing the outcomes with the woman

Treatment decisions, advice and monitoring for women who are planning a pregnancy, pregnant or in the postnatal period

Information and advice. Depending on individual circumstances, discuss:

- The uncertainty over the benefits, risks and harms of treatments
- The likely benefits of each treatment, considering the severity of the mental health problem
- The woman's response to any previous treatment
- The background risk of harm to the woman and the fetus or baby associated with the mental health problem, and the risk to mental health and parenting associated with no treatment
- The risks or harms to the woman and the fetus or baby associated with each treatment option and with stopping or changing a treatment
- The possibility of the sudden onset of symptoms, particularly in the first few weeks after childbirth (e.g. in bipolar disorder)
- The need for prompt treatment because of the potential effect of an untreated mental health problem on the fetus or baby

Starting, using and stopping treatment

Before starting, discuss with the woman the higher threshold for pharmacological interventions arising from the changing risk–benefit ratio for psychotropic medication at this time and the likely benefits of a psychological intervention

If psychotropic medication with known teratogenic risk was taken at any time in the first trimester:

- Confirm the pregnancy as soon as possible
- Explain that stopping or switching the medication after pregnancy is confirmed may not remove the risk of fetal malformations
- Offer screening for fetal abnormalities and counselling about continuing the pregnancy
- Explain the need for additional monitoring and the risks to the fetus if she continues to take the medication.
- Seek advice from a specialist if there is uncertainty over the risks associated with specific drugs

Antidepressants. When choosing one, take into account:

- The woman's previous response to these drugs
- The stage of pregnancy
- What is known about the reproductive safety of these drugs (e.g. the risk of fetal cardiac abnormalities and persistent pulmonary hypertension in the newborn baby)
- The uncertainty about whether any increased risk to the fetus and other problems for the woman or baby can be attributed directly to these drugs or might be caused by other factors

- The risk of discontinuation symptoms in the woman and neonatal adaptation syndrome in the baby with most TCAs, SSRIs and (S)NRIs, in particular paroxetine and venlafaxine.

Recognizing mental health problems in pregnancy and the postnatal period and referral

At a woman's first contact with primary care or her booking visit, and during the early postnatal period, consider asking the following depression identification questions:

- 'During the past month, have you often been bothered by feeling down, depressed or hopeless?'
- 'During the past month, have you often been bothered by having little interest or pleasure in doing things?'

Also consider asking about anxiety using the 2-item Generalized Anxiety Disorder scale (GAD-2):

- 'Over the last 2 weeks, how often have you been bothered by feeling nervous, anxious or on edge?'
- 'Over the last 2 weeks, how often have you been bothered by not being able to stop or control worrying?'

(S)NRI, (serotonin-) noradrenaline reuptake inhibitor; SSRI, selective serotonin reuptake inhibitor; TCA, tricyclic antidepressant.

Table 1
Clinical features of postpartum psychosis, postnatal depression and the baby blues

| | 'Baby blues' | Postnatal depression | Postpartum psychosis |
|------------------------------|--|---|---|
| Incidence per delivery | Around 50% | Around 5–15% | Around 0.1% |
| Typical onset after delivery | Around days 2–5 | Within 6 months | First 2 weeks |
| Duration | Few days | Weeks to months | Weeks to months |
| Symptoms include | Depressed mood, irritability, lability of mood, crying | Depressed mood, lack of pleasure, poor sleep/appetite, suicidal thoughts, self-blame/guilt | Elated, irritable or depressed mood, lability of mood, confusion/perplexity, psychotic symptoms including delusions and hallucinations, rapidly changing clinical picture |
| Treatment | Requires no intervention | Self-help strategies (e.g. exercise, computerized CBT and guided self-help), non-directive counselling, psychological therapies (e.g. CBT, IPT), antidepressant medication (e.g. sertraline). Can usually be treated at home, but severe cases may need admission – jointly with baby if possible | Antipsychotic medication (e.g. olanzapine), antidepressant medication, mood stabilizers (e.g. lithium), support and counselling. Often requires admission – jointly with baby if possible |
| Prognosis | Transient. Increased risk of subsequent postnatal depression | Can be severe and long lasting without treatment. At risk of further puerperal and non-puerperal affective episodes | Severe but prognosis of recovery from puerperal episode is good. Remains at risk of further puerperal and non-puerperal affective episodes |

CBT, cognitive–behavioural therapy; IPT, interpersonal therapy.

Rates of postpartum psychosis per 1000 deliveries for women in the general population, bipolar women and women who have suffered a previous episode of postpartum psychosis

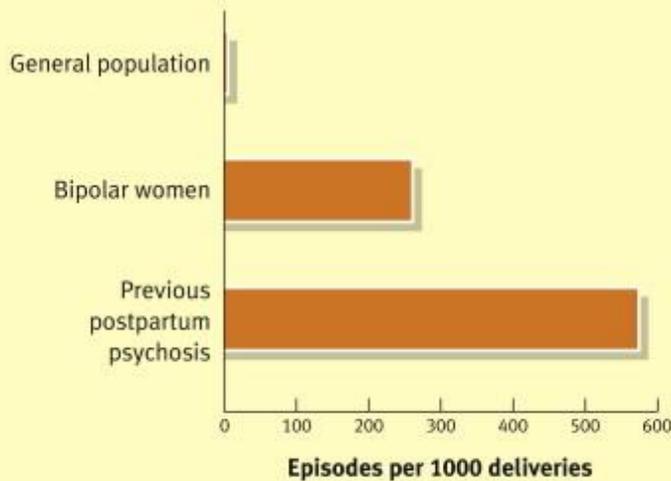


Figure 1

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