CLINICAL PEARLS IN PERINATAL MENTAL HEALTH

Developed During Symposium on Interface between Obstetrics and Mental Health, 22nd Jan, 2013
Perinatal Psychiatric Services, NIMHANS

MENTAL HEALTH IN PREGNANCY

Common psychological issues during pregnancy

- Anxiety, fears and insecurity
- Sleeping and eating disturbances
- Mood changes
- Irritability
- Self esteem issues
- Concerns with body image
- Depressed mood

Screening questions –

SCREENING QUESTIONS TO ASSESS RISK OF MENTAL HEALTH PROBLEMS IN PREGNANCY AND POSTPARTUM. These questions should be made part of the antenatal screening. Each of this is a risk factor and more than one may actually indicate higher risk and need for liaison with a mental health professional.

1. Do you have an earlier history of any mental health problem and have you ever taken any treatment from a mental health professional? Have you ever used any antidepressants or other psychotropic medication?
2. Do you have a Family History of psychiatric disorder? - Specially enquire about pregnancy related psychiatric problems in women relatives.
3. What has been your Mood State in the last few months?
4. What is your Current Mood state- last one week?

Depression – Screening questions recommended by NICE Guidelines, UK -

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

A third question should be considered if the woman answers 'yes' to either of the initial questions

Is this something you feel you need or want help with?

Psychosocial assessment (Patient to be preferably interviewed alone and confidentiality maintained)

1. How satisfied are you with your marital life? What level of support do you have from your husband?
2. Do you have adequate support from your family? Will they help you during pregnancy? Is there support to ensure adequate nutrition and antenatal care
3. Have you been subjected to any domestic violence? How severe is it? (this is important as studies have shown high rates of violence during pregnancy which might lead to abortions).
4. Have you ever tried to harm yourself in the past? – what might have been the reason?
5. Do you use any of the following- sleeping pills/tobacco (smoking or chewing)/alcohol)- if yes, how much and how often?
6. How concerned are you about the gender of your child and is there any pressure from family to have a male child?

In Addition to the Screening questions for Depression also assess for anxiety and panic disorder

Do you feel tense, on the edge and unable to relax most of the time?

Do you experience episodes of intense anxiety during which you have giddiness, palpitations, sweating and feelings that you might have a heart attack?

Management of Mental Health Problems in Pregnancy

1. **Handle it Yourself** - For mild problems such as Mild Depression and Anxiety – Reassurance and Education often are enough
2. **Refer to a Psychologist/ Counsellor/Psychiatrist -** For Moderate problems i.e. when you feel it is interfering with her nutrition and health, is more or less continuous and does not appear to come down with simple reassurance
3. **Consider immediate Referral to a Psychiatrist –** If the problem is persisting, severe, the woman reports self harm or suicidal ideas, if there is a past history of psychiatric treatment or psychiatric disorder

NOTE- FOR MILD TO MODERATE PROBLEMS IN PREGNANCY- PSYCHOLOGICAL MANAGEMENT IS PREFERRED. HOWEVER, IF A WOMAN NEEDS PSYCHOTROPIC MEDICATION, IT SHOULD NOT BE DENIED.

A PROPER TREATMENT PLAN IN COLLABORATION WITH THE PSYCHIATRIST AND OBSTETRICIAN CAN ENSURE MINIMISATION OF RISK WITH MAXIMUM BENEFIT TO THE MOTHER.

MENTAL HEALTH IN THE POSTPARTUM

COMMON MENTAL HEALTH PROBLEMS IN THE POSTPARTUM PERIOD- Blues, Depression and Anxiety Disorders

When do you suspect Depression (or is it just Postpartum Blues)?

- **Blues-** Mild depressive symptoms, tearfulness (often for no discernible reason), anxiety, irritability, mood lability, increased sensitivity and fatigue
- Peak four to five days after delivery, may last hours to days and resolve by the 10th postnatal day and subsides after that. ***Severe Blues can lead to Depression.***
- **Post-partum depression** lasts longer than the blues, has all the symptoms of depression as in ante-natal depression and may need treatment with medication/ therapy

PERIODS OF RISK

	PERIOD PREVALENCE
From Conception To Birth	12.7 %
From Birth To Three Months	17 %

UNCOMMON BUT IMPORTANT PSYCHIATRIC CONDITIONS IN THE POSTPARTUM

POSTPARTUM PSYCHOSIS

RECURRENCE OF UNDERLYING PSYCHIATRIC DISORDER

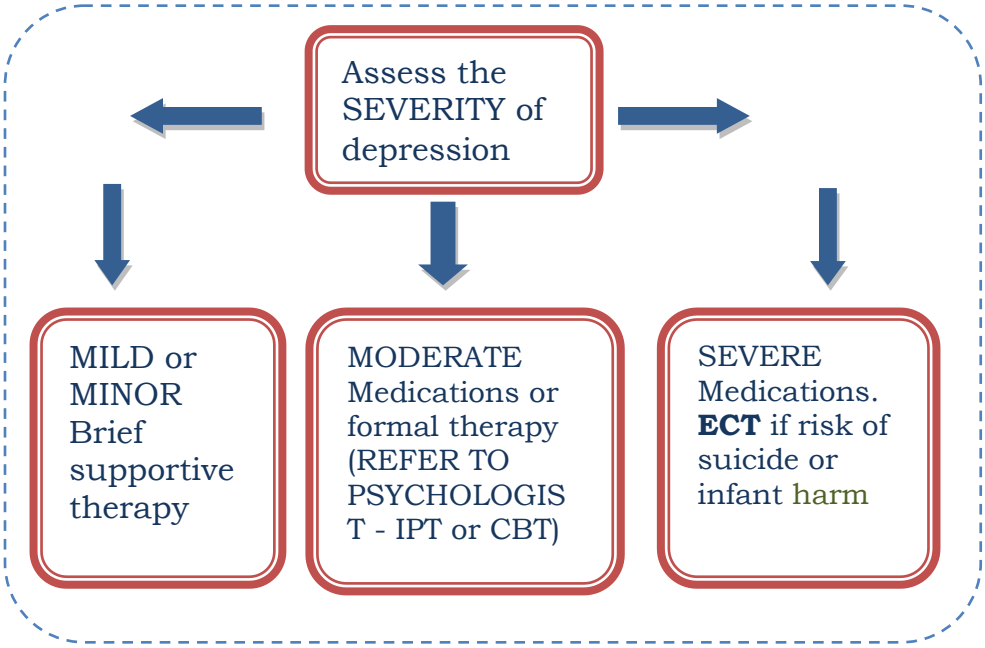
MOTHER INFANT BONDING DISORDER

THERE IS AN URGENT NEED TO REFER

If patient reports that she has death wishes or has thought about committing suicide, there is poor oral intake or neglect of child

IMPACT OF POSTPARTUM PSYCHIATRIC DISORDER ON THE MOTHER AND INFANT

- Lack of bonding with infant – risk of neglect or abuse
- Affects cognitive skills, expressive language development and attention of the infant
- Lasting effects on a woman's confidence in herself as a mother
- May influence lactation



MOTHER INFANT BONDING DISORDERS

- Rejection of infant, over involvement, separation anxiety, anger towards infant
- Delayed development of maternal response

Causes: Unwanted pregnancy, delayed infant development, maternal psychiatric illness, difficult childbirth and poor relationship with spouse

Treatment includes

- Providing reassurance and education and Improving family support

- Encouraging mother infant non threatening interactions such as massage, play
- Video-taped interaction and feedback
- Treatment of underling psychiatric condition

Psychotropics in pregnancy (Scottish Intercollegiate Guidelines Network. SIGN 127, 2012)

Key Points – Psychotropics in pregnancy

- **Women with pre existing psychiatric problems should have a planned pregnancy**
- **Ensure pre conception counselling and folic acid**
- **Assess impact of psychotropic drugs on fertility**
- **If using drugs- Monotherapy and Lowest dose**
- **Early detection of mental health problems**
- **Liaison between obstetrician and psychiatrist**
- **Adjunctive psychosocial treatment**
- **Assess past history of relapse and recurrence**
- **Use drugs that are known**
- **Can the patient do without medication?**
- **Do not stop drugs abruptly**
- **Informed Choice and Documentation**

Antidepressants

Review antidepressant therapy as soon as possible in pregnancy to discuss whether medication should be continued and any other alternative pharmacological or non-pharmacological treatments initiated. In view of the association with harms to the fetus and neonate, paroxetine should not generally be initiated as first line therapy in pregnancy. For women already prescribed paroxetine an evaluation of individual risks and benefits should be carried out before a decision is made to continue use or switch to another antidepressant.

Choice of antidepressant in pregnancy should take into account implications for breastfeeding.

Since the evidence base for safety of antidepressant prescribing in pregnancy is a rapidly developing area, clinicians should update their knowledge frequently.

Lithium

An individualized psychiatric care plan, involving maternity services and the patient, for lithium management throughout pregnancy and the peripartum is needed. This should include consideration of:

- frequency of monitoring and dose adjustment
- potential for interaction with medications prescribed in pregnancy
- preparation for and mode of delivery
- risks to the neonate

Women taking lithium in early pregnancy should be offered detailed ultrasound scanning for fetal abnormality.

Where a woman is taking lithium in pregnancy, mental health services should provide maternity services with information on the recognition of lithium toxicity, lithium-drug interactions and pregnancy-related events which may precipitate toxicity.

Antiepileptic drugs

C - In view of the risk of early teratogenicity and longer term neurobehavioural toxicity, valproate (when used as a mood stabilizer) **should not** be routinely prescribed to women of childbearing potential.

If there is no alternative to valproate treatment for a woman of childbearing potential, long-acting contraceptive measures should be recommended.

C - **Valproate should be avoided** as a mood stabilizer in pregnancy.

D - All women taking antiepileptic drugs as mood stabilizers should be prescribed a **daily dose of 5 mg of folic acid** from preconception until at least the end of the first trimester.

Women taking antiepileptic drugs in early pregnancy should be offered detailed ultrasound scanning for fetal abnormality.

Maternal lamotrigine levels should be monitored throughout pregnancy and the early postpartum period.

Antipsychotics

C - Women taking antipsychotics during pregnancy should be monitored for alterations in fetal growth. Additional monitoring for blood glucose abnormalities is required where olanzapine or clozapine are prescribed.

Hypnotics and sedatives

C - In women taking benzodiazepines the need for continued use in pregnancy should be reviewed and use should be restricted to short term and low dose where possible. Consideration should be given to tapering the dose prior to childbirth.

Psychotropics in Lactation (Scottish Intercollegiate Guidelines Network. Sign 127, 2012)

Antidepressants

D - Avoid doxepin for treatment of depression in women who are breast feeding.

If initiating selective serotonin reuptake inhibitor treatment in breast feeding, then fluoxetine, citalopram and escitalopram should be avoided if possible. Sertraline or Tricyclics maybe preferred.

When initiating antidepressant use in women who are breastfeeding, both the absolute dose and the half-life should be considered.

Lithium

D - In view of the potential risks to the infant of a breastfeeding mother taking lithium, mothers should be encouraged to avoid breast-feeding.

Antiepileptic drugs

Antiepileptic mood stabilizer prescription is not, of itself, a contraindication to breastfeeding, but decisions should be made individually with the woman, after full discussion of the risks and benefits. These drugs may be avoided if the infant is premature or has liver problems.

Hypnotics and sedatives

If a benzodiazepine is required during breast feeding short-acting agents should be prescribed in divided doses. Mothers should be advised not to stop medication suddenly and to contact their doctor if the infant is observed to have sleepiness, low energy or poor suckling.

Antipsychotics

D - Women who are taking clozapine should not breast feed.

All breastfed infants should be monitored for sedation and extra-pyramidal adverse effects where mothers are taking antipsychotic medications.

Recommendations are graded **A B C D** to indicate the strength of the supporting evidence.

References –

National Collaborating Centre for Mental Health. Antenatal and postnatal mental health: clinical management and service guidance. NICE Clinical Guideline CG45. London: National Institute for Health & Clinical Excellence; 2007. Available from: www.nice.org.uk/CG045

Scottish Intercollegiate Guidelines Network. Management of perinatal mood disorders. Quick Reference Guide. SIGN 127. March 2012 Available from: www.sign.ac.uk/pdf/qrg127.pdf

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For further Updates and Details please visit our website:

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