Perinatal MH Disorders- Introduction

Dr. Raju Lakshmana

Consultant Psychiatrist

Disclosures

- Private Practice- www.holisticmedicalservices.com.au
- Clinical Director of Perinatal MH services @ Mitcham Private Hospital

Objectives

- Why- epidemiology, impacts, costs
- Special Issues in this period
- Screening and Early detection
- Risk Factors
- Assessment

Prevalence and characteristics

- Perinatal depression[1]
  - 11-15%, a third begins in pregnancy and another third pre-pregnancy
  - Generally co-morbid with prominent anxiety
- Perinatal Anxiety[2]
  - 13-15%
  - Mostly obsessive compulsive quality
  - PTSD is more common than estimated, triggered by traumatic experiences
- Psychotic disorders[2]
  - Higher risk of having a Bipolar episode (2.8%)
  - Pregnancy has a protective effect, but post-partum is a high risk period

1. Gavin NI, Gaynes BN, Lohr KN, Meltzer-Brody S, Gartlehner G, Swinson T. Perinatal depression: a systematic review of prevalence and incidence. *Obstet Gynecol* 2005; **106:** 1071–83.
2. Vesga-López O, Blanco C, Keyes K, Olfson M, Grant BF, Hasin DS. Psychiatric disorders in pregnant and postpartum women in the United States. *Arch Gen Psychiatry* 2008; **65:** 805–15.

Effects of Antenatal Depression on the pregnancy/ fetus

- Increased risk of premature delivery
- Low birth weight (and IUGR) in low- middle income countries
- No association with pre-eclampsia, APGAR scores, or admission to neonatal intensive care units

Grigoriadis S, VonderPorten EH, Mamisashvili L, et al. The impact of maternal depression during pregnancy on perinatal outcomes: a systematic review and meta-analysis. *J Clin Psychiatry* 2013; **74:** e321–41.

Grote NK, Bridge JA, Gavin AR, Melville JL, Iyengar S, Katon WJ.A meta-analysis of depression during pregnancy and the risk of preterm birth, low birth weight, and intrauterine growth restriction. *Arch Gen Psychiatry* 2010; **67:** 1012–24.

Stein, A., Pearson, R.M., Goodman, S.H., Rapa, E., Rahman, A., McCallum, M., Howard, L.M. and Pariante, C.M., 2014. Effects of perinatal mental disorders on the fetus and child. *The Lancet*, *384*(9956), pp.1800-1819.

Effects of Depression on Infant/ Child

Depression in Antenatal Period

- Emotional problems
- Depression in late adolescence
- Externalizing behaviors including antisocial
- Insecure attachments
- Underweight (LMICs)
- Overweight (HICs)

Depression in Postnatal Period

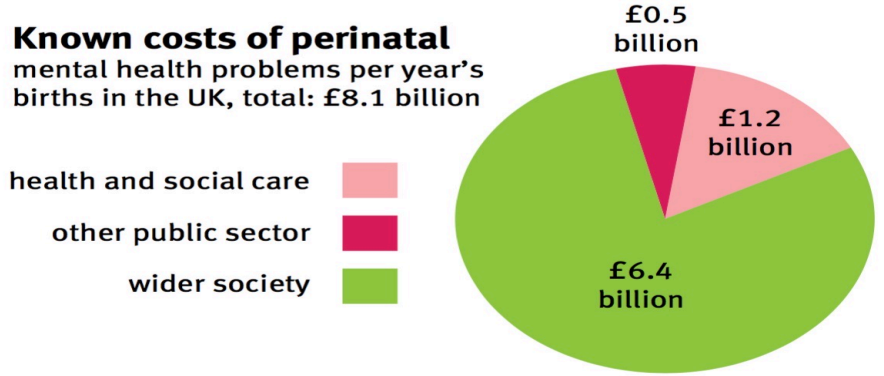
- Difficulties in emotional regulation and social behavior
- Depression during adolescence
- ADHD and externalizing behavior
- Insecure attachments
- **Ability to learn, achievement of milestones, language***
- **General cognitive development***

Stein, A., Pearson, R.M., Goodman, S.H., Rapa, E., Rahman, A., McCallum, M., Howard, L.M. and Pariante, C.M., 2014. Effects of perinatal mental disorders on the fetus and child. *The Lancet*, *384*(9956), pp.1800-1819.

Costs

Key points from the report

Known costs of perinatal mental health problems per year's births in the UK, total: £8.1 billion



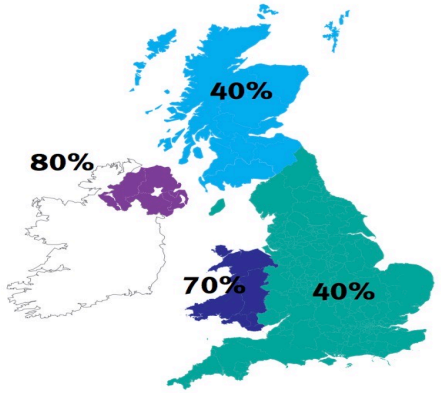
Of these costs

28% relate to the mother

72% relate to the child

Up to 20% of women develop a mental health problem during pregnancy or within a year of giving birth

Women in around half the UK have NO access to specialist perinatal mental health services

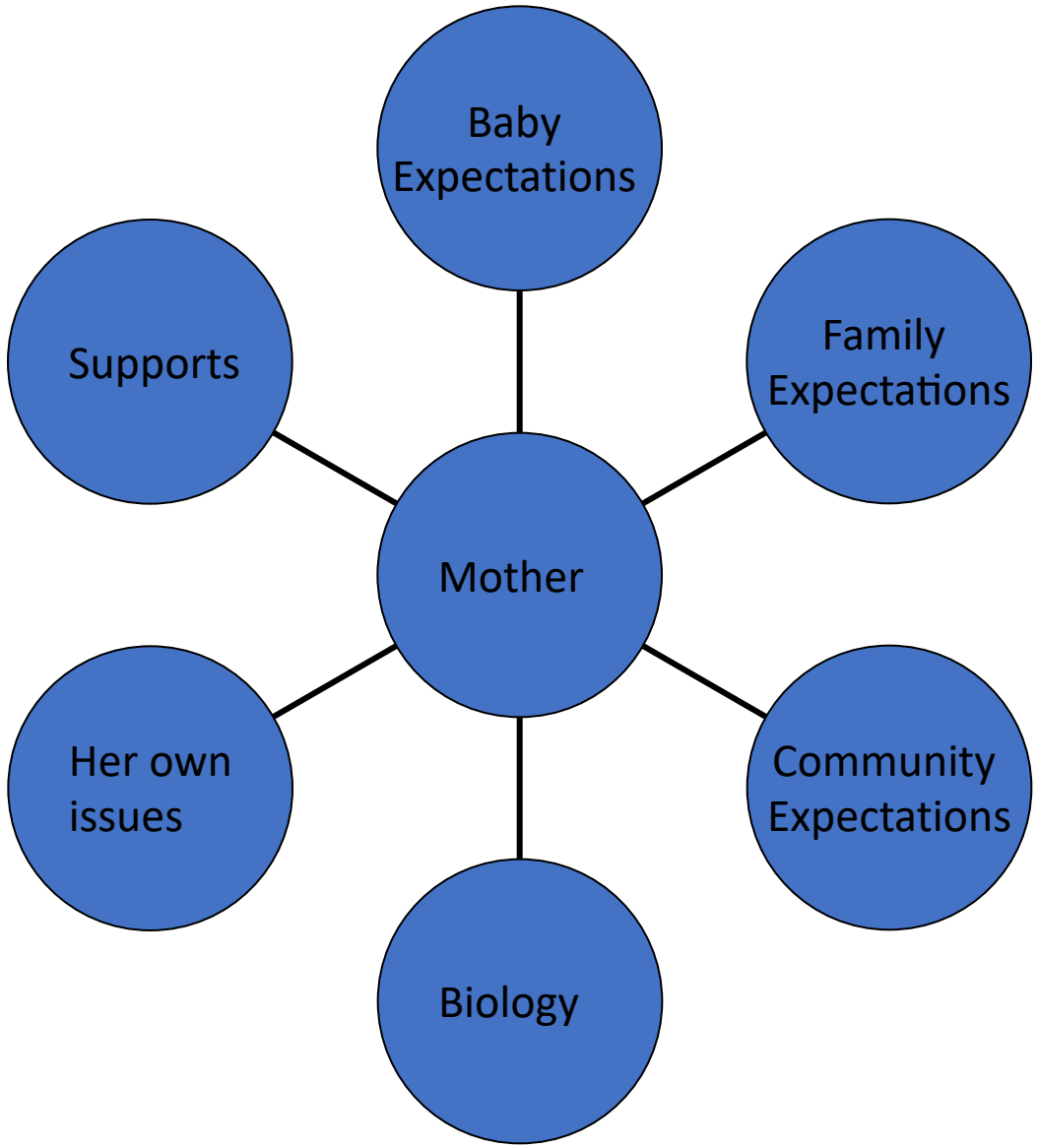


Suicide is a leading cause of death for women during pregnancy and in the year after giving birth

Costs v improvement

The cost to the public sector of perinatal mental health problems is **5 times** the cost of improving services.

Bauer, A., Parsonage, M., Knapp, M., Iemmi, V. and Adelaja, B., 2014. Costs of perinatal mental health problems.



Pregnancy:
Major life event
Hormonal/ Physiological changes
Social/ Lifestyle changes
Psychological issues- unwanted pregnancy, ideas about motherhood
Complicated pregnancies
Miscarriage/ abortion is associated with Guilt and sense of failure

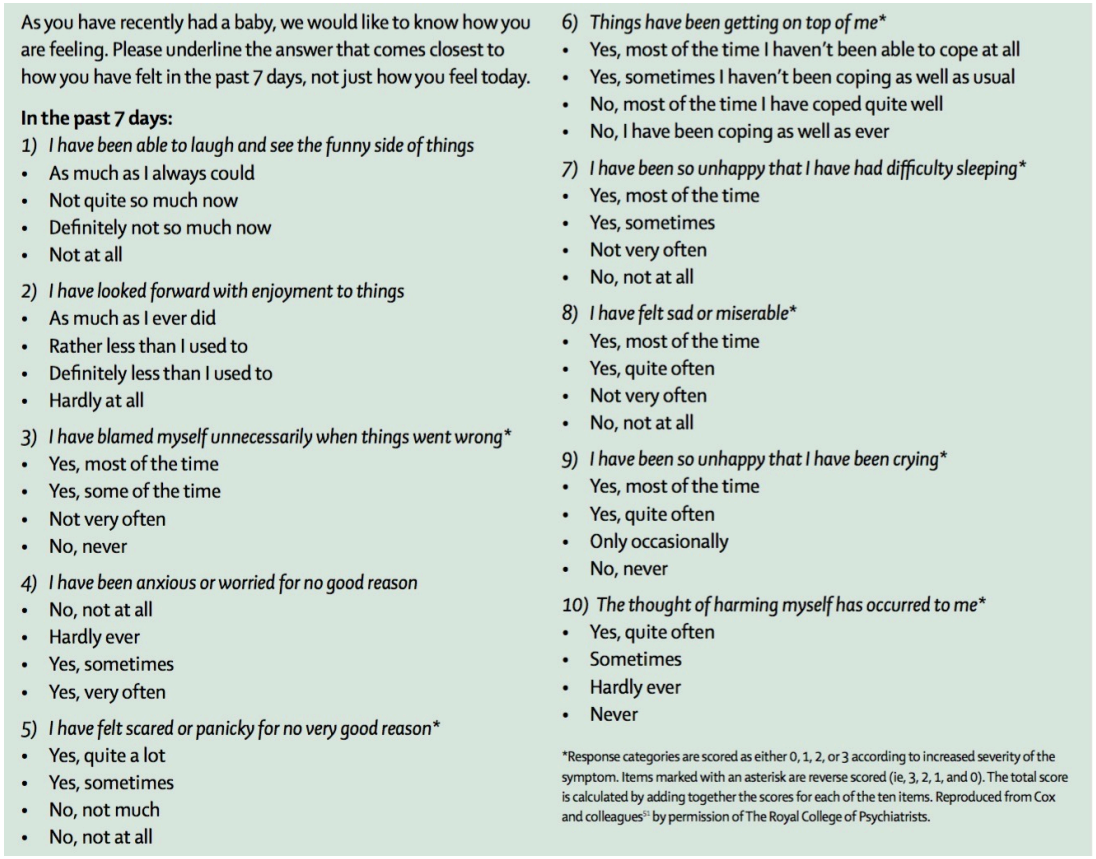
Labor:
Can be a re-experience of trauma for some (VOC, abuse)
Complications may result in separation from baby and resultant guilt
Some may feel cheated when the labor plan changes!

Pueperium

- Significant physiological changes
- Significant Lifestyle Change: grief/loss, identity, relationships, fatigue
- Parenting styles based on own experiences
- Issues with Breastfeeding
- Bonding/ Mother- baby ‘fit’
- Issues around “sick” baby
- Supports

Screening

Buist, A.E., Barnett, B.E., Milgrom, J., Pope, S., Condon, J.T., Ellwood, D.A., Boyce, P.M., Austin, M.P.V. and Hayes, B.A., 2002. To screen or not to screen-that is the question in perinatal depression. *Medical Journal of Australia*, *177*(7), p.S101.



As you have recently had a baby, we would like to know how you are feeling. Please underline the answer that comes closest to how you have felt in the past 7 days, not just how you feel today.

In the past 7 days:

1) *I have been able to laugh and see the funny side of things*
- As much as I always could
- Not quite so much now
- Definitely not so much now
- Not at all

2) *I have looked forward with enjoyment to things*
- As much as I ever did
- Rather less than I used to
- Definitely less than I used to
- Hardly at all

3) *I have blamed myself unnecessarily when things went wrong**
- Yes, most of the time
- Yes, some of the time
- Not very often
- No, never

4) *I have been anxious or worried for no good reason*
- No, not at all
- Hardly ever
- Yes, sometimes
- Yes, very often

5) *I have felt scared or panicky for no very good reason**
- Yes, quite a lot
- Yes, sometimes
- No, not much
- No, not at all

6) *Things have been getting on top of me**
- Yes, most of the time I haven't been able to cope at all
- Yes, sometimes I haven't been coping as well as usual
- No, most of the time I have coped quite well
- No, I have been coping as well as ever

7) *I have been so unhappy that I have had difficulty sleeping**
- Yes, most of the time
- Yes, sometimes
- Not very often
- No, not at all

8) *I have felt sad or miserable**
- Yes, most of the time
- Yes, quite often
- Not very often
- No, not at all

9) *I have been so unhappy that I have been crying**
- Yes, most of the time
- Yes, quite often
- Only occasionally
- No, never

10) *The thought of harming myself has occurred to me**
- Yes, quite often
- Sometimes
- Hardly ever
- Never

*Response categories are scored as either 0, 1, 2, or 3 according to increased severity of the symptom. Items marked with an asterisk are reverse scored (ie, 3, 2, 1, and 0). The total score is calculated by adding together the scores for each of the ten items. Reproduced from Cox and colleagues[51] by permission of The Royal College of Psychiatrists.

- EPDS:
  - 68-86% sensitivity, 78-96% specificity
  - Self-report tool (10 questions)
  - Positive Predictive Value 70-90%
  - Frequency:
    - Antenatal:
      - 10- 12 weeks
      - 24- 28 weeks
      - 36 weeks
    - Postnatal:
      - 6-8 weeks
      - 12 weeks

RISK FACTORS

Antenatal Depression

- **DV**
- Life stress, major negative **life event**
- Absence of social or relationship **support**
- **Past history**
- Unwanted pregnancy
- Anxiety

Postnatal Depression

- **DV**/ Previous abuse
- Negative **life events**
- **Marital Difficulties**
- **Past history**, Anxiety, Substance misuse
- Migration status
- Neuroticism
- Multiple Births
- Complications in baby
- Comorbid medical illnesses

Lancaster CA, Gold KJ, Flynn HA, Yoo H, Marcus SM, Davis MM. Risk factors for depressive symptoms during pregnancy: a systematic review. *Am J Obstet Gynecol* 2010; **202:** 5–14
Robertson E, Grace S, Wallington T, Stewart DE. Antenatal risk factors for postpartum depression: a synthesis of recent literature. *Gen Hosp Psychiatry* 2004; **26:** 289–95.

Assessment

- Include Baby and partner/ family member/ carer
- Anxiety is prominent: safety and care worries
- Check for supports, family of origin, her attachment style
- Family history often present (but undiagnosed)
- Breastfeeding, another pregnancy, attitudes
- Sleep, medical issues, other medications
- Validate, rephrase and support (“No Instruction Manual”)
- Don’t rush to diagnose or start medications
- Check Risks- parent, child, other dependents, other domains, **substances**

Diagnostic considerations

- Part of the normal spectrum
- Adjustment
- New disorder vs recurrence vs exacerbation
- Formulate- helps to engage and plan treatment
- Effects on family, especially partner, other kids, etc
- Multiaxial diagnosis may be useful framework

Perinatal MH Disorders- Assessment

Dr. Raju Lakshmana

Consultant Psychiatrist

Disclosures

- Private Practice- www.holisticmedicalservices.com.au
- Clinical Director of Perinatal MH services @ Mitcham Private Hospital

Objectives

- Comprehensive assessment including Risk Assessment
- Formulation
- Differential and working Diagnosis
- Initial Management

Assessment

- Mother
- Baby
- Environment- Supports and Stresses
- Socio-cultural issues: Attitudes, Preferences, Influences
- Goals and Expectations
- Other professionals involved- Obstetrician, MHCN, Midwife, CPS
- Engaging the partner/ other care providers

RISK FACTORS

Antenatal Depression

- **DV**
- Life stress, major negative **life event**
- Absence of social or relationship **support**
- **Past history**
- Unwanted pregnancy
- Anxiety

Postnatal Depression

- **DV**/ Previous abuse
- Negative **life events**
- **Marital Difficulties**
- **Past history**, Anxiety, Substance misuse
- Migration status
- Neuroticism
- Multiple Births
- Complications in baby
- Comorbid medical illnesses

Lancaster CA, Gold KJ, Flynn HA, Yoo H, Marcus SM, Davis MM. Risk factors for depressive symptoms during pregnancy: a systematic review. *Am J Obstet Gynecol* 2010; **202:** 5–14
Robertson E, Grace S, Wallington T, Stewart DE. Antenatal risk factors for postpartum depression: a synthesis of recent literature. *Gen Hosp Psychiatry* 2004; **26:** 289–95.

Assessment

- Include Baby and partner/ family member/ carer
- Anxiety is prominent: safety and care worries
- Check for supports, family of origin, her attachment style
- Family history often present (but undiagnosed)
- Breastfeeding, another pregnancy, attitudes
- Sleep, medical issues, other medications
- Validate, rephrase and support (“No Instruction Manual”)
- Don’t rush to diagnose or start medications
- Check Risks- parent, child, other dependents, other domains, **substances**

Mother

- Demographics including work/ education (identity)
- Past and Family History of mental illness (genetics), Medical and treatment history
- Developmental History (personality style (self-others-world) and coping strategies)
- Bonding
- Breastfeeding, plans for another child, priorities
- Of course, HOPI
- MSE and Risks: “better insight more distressed”

Baby/ Pregnancy

- Planned, Wanted
- Temperament (do they remind them of anyone from their past)
- Relational issues (Bonding)
- Previous pregnancies: outcomes, effects
- Feeding/ sleep issues
- Medical issues
- How do they respond to other care givers
- Other children/ dependents

Environment

- Partner and their role/ involvement
- Supports- practical vs emotional
- Other stressors and commitments
- Safety and Stability
- IPR charting may be useful

Socio-cultural issues

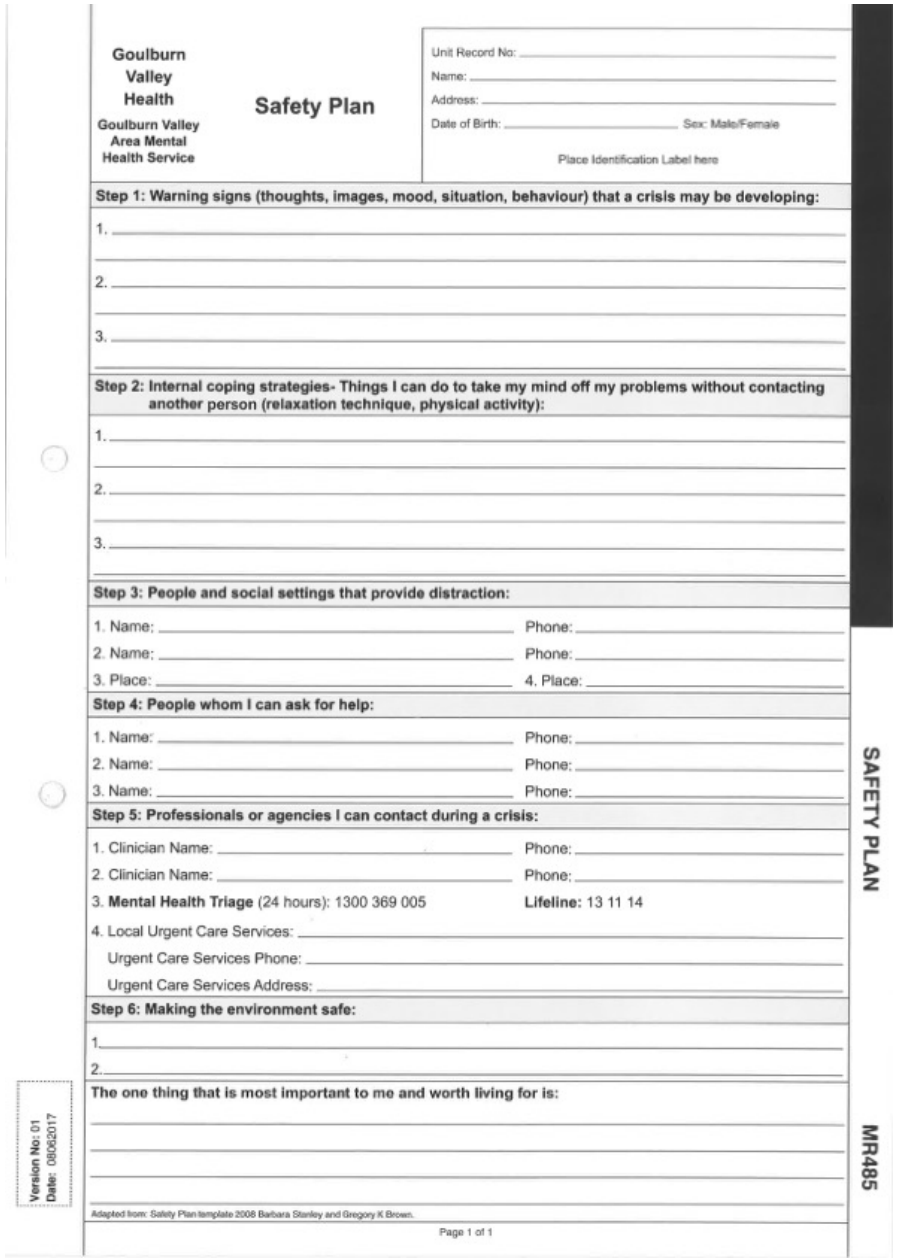
- Attitudes
- Preferences
- Belief systems
- Own experiences
- Others influencing it
- Goals and Expectations (realistic vs unrealistic)

Others involved

- Communication
- Collaboration
- Liaison
- Issues with CPS and other government agencies

Risk Assessment

- Mother
- Baby
- Other dependents
- Other domains- relationship, work, financial, driving (mobility)
- Other supports: how reliable and involved they are
- Safety Plan



Goulburn Valley Health

Goulburn Valley Area Mental Health Service

Safety Plan

Unit Record No: _____

Name: _____

Address: _____

Date of Birth: _____ Sex: Male/Female

Place Identification Label here

Step 1: Warning signs (thoughts, images, mood, situation, behaviour) that a crisis may be developing:

1. _____

2. _____

3. _____

Step 2: Internal coping strategies- Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity):

1. _____

2. _____

3. _____

Step 3: People and social settings that provide distraction:

1. Name: _____ Phone: _____

2. Name: _____ Phone: _____

3. Place: _____ 4. Place: _____

Step 4: People whom I can ask for help:

1. Name: _____ Phone: _____

2. Name: _____ Phone: _____

3. Name: _____ Phone: _____

Step 5: Professionals or agencies I can contact during a crisis:

1. Clinician Name: _____ Phone: _____

2. Clinician Name: _____ Phone: _____

3. **Mental Health Triage** (24 hours): 1300 369 005 **Lifeline:** 13 11 14

4. Local Urgent Care Services: _____

Urgent Care Services Phone: _____

Urgent Care Services Address: _____

Step 6: Making the environment safe:

1. _____

2. _____

The one thing that is most important to me and worth living for is:

_____

_____

_____

_____

Adapted from: Safety Plan template 2008 Barbara Stanley and Gregory K Brown.

Page 1 of 1

Version No: 01
Date: 08062017

SAFETY PLAN

MR485

Assessment to inform

- Formulation (understanding of the person with illness)
- Diagnostic possibilities (illness)
- Initial Management
  - Risks involving mother and/ or baby: where to treat and whom to involve
  - Further assessment, referrals and investigations
  - Initiate treatment
    - Education and support
    - Resources and linkages
    - Normalization where required
    - Psychological/ self management strategies
    - Medication

Perinatal MH Disorders- Treatment

Dr. Raju Lakshmana

Consultant Psychiatrist

Acknowledgement to the country and Disclosures

- Private Practice- www.holisticmedicalservices.com.au
- Clinical Director of Perinatal MH services @ Mitcham Private Hospital

Objectives

- Psychosocial interventions are critical to recovery
- Parenting is the sole “modifying factor”
- Psychological Interventions
- Social Interventions
- Parenting Interventions

RISK FACTORS

Antenatal Depression

- **DV**
- Life stress, major negative **life event**
- Absence of social or relationship **support**
- **Past history**
- Unwanted pregnancy
- Anxiety

Postnatal Depression

- **DV**/ Previous abuse
- Negative **life events**
- **Marital Difficulties/ Support**
- **Past history**, Anxiety, Substance misuse
- Migration status
- Neuroticism
- Multiple Births
- Complications in baby
- Comorbid medical illnesses

Lancaster CA, Gold KJ, Flynn HA, Yoo H, Marcus SM, Davis MM. Risk factors for depressive symptoms during pregnancy: a systematic review. *Am J Obstet Gynecol* 2010; **202:** 5–14
Robertson E, Grace S, Wallington T, Stewart DE. Antenatal risk factors for postpartum depression: a synthesis of recent literature. *Gen Hosp Psychiatry* 2004; **26:** 289–95.

Parenting is the only moderating factor

- Research demonstrates that all screening and interventions have no direct effect on outcomes for the child
- They all seem to improve parenting and therefore mitigate/ improve outcomes
- Focussing solely on maternal mental state may not help
- Parenting role can be taken on by other care providers
- Fathers and other family members need to be involved in management

Three Core Concepts in Early Development

2 Serve & Return Interaction Shapes Brain Circuitry

NATIONAL SCIENTIFIC COUNCIL ON THE DEVELOPING CHILD

Center on the Developing Child HARVARD UNIVERSITY

Mental state and it's relationship to Parenting

- Quality of Parenting is affected by:
  - Ability to respond to environment
  - Engage with infant
  - Provide contingent responses to infant's cues
  - Thinking of child's perspectives, thoughts and feelings
  - To support infant when distressed
- Secure Attachment
  - Availability and appropriate responsiveness
  - Treating children as individuals

Stein A, Craske MG, Lehtonen A, et al. Maternal cognitions and mother-infant interaction in postnatal depression and generalized anxiety disorder. *J Abnorm Psychol* 2012; **121:** 795–809.
Bakermans-Kranenburg MJ, van IJzendoorn MH, Juffer F. Less is more: meta-analyses of sensitivity and attachment interventions in early childhood. *Psychol Bull* 2003; **129:** 195–215.

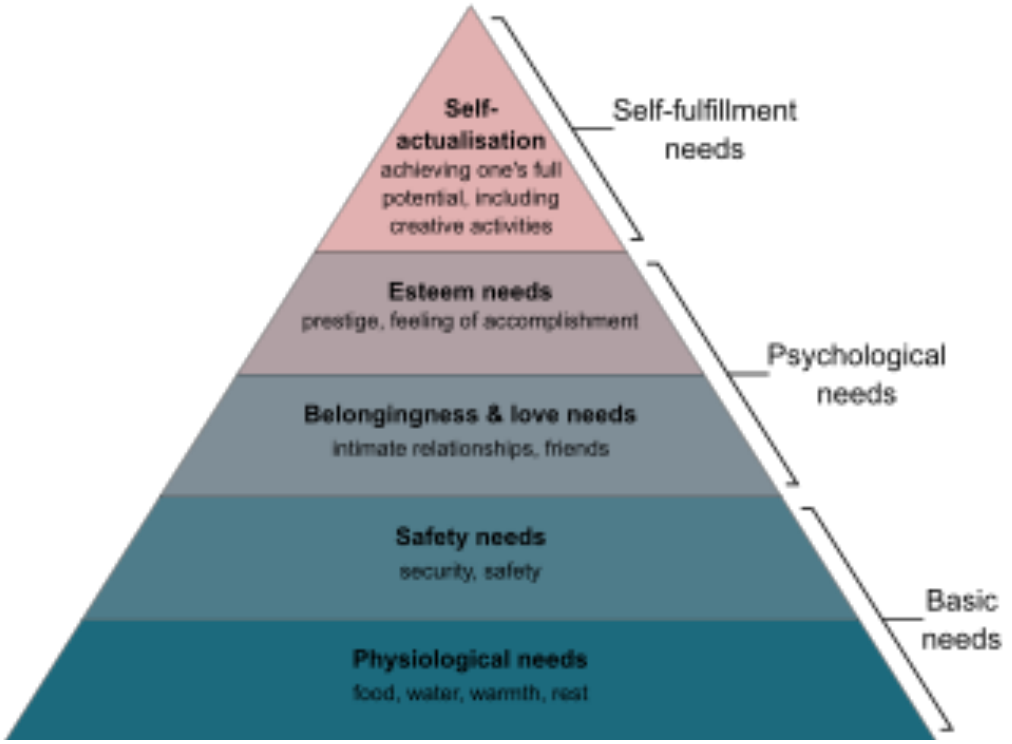
Other Moderating Factors

- Socioeconomic circumstances[1]
  - Practical Support
  - Finances
- Partner Support and well being
- **Amelioration of symptoms improves mother-infant interactions and play[2]**

1. Lovejoy MC, Graczyk PA, O'Hare E, Neuman G. Maternal depression and parenting behavior: a meta-analytic review. *Clin Psychol Rev* 2000; **20:** 561–92.
2. Goodman SH, Broth MR, Hall CM, Stowe ZN. Treatment of postpartum depression in mothers: secondary benefits to the infants. *Infant Ment Health J* 2008; **29:** 492–513.

Social Interventions

- Marslow's hierarchy
- Support:
  - Formal (MHCN, GP, Psychology, etc) and Informal (partner, family, friends)
  - Practical vs Emotional
  - Behavioral Psychoeducation models assist
- Health professionals can advocate (e.g shifts, prioritization, subsidy, etc.)

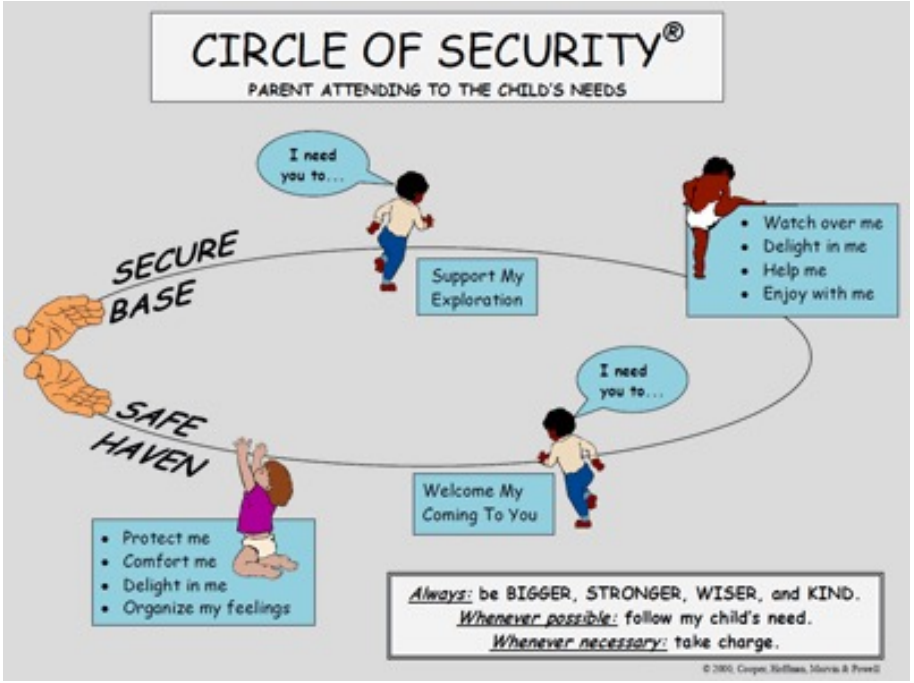


Psychological

- General: Anxiety management, sleep hygiene, lifestyle changes, sensory modulation
- Formulation Informed: CBT, IPT, Psychodynamic/analytic, ERP, Trauma Informed
- Review/ Evaluate: use scales, specialist reviews, feedback from family and other MDT colleagues
- Don’t forget the parenting role: Temper your approach, see the parent with baby/ children
- It is OK to be eclectic
- Recruit co-therapists in the family/ friends

PARENTING INTERVENTIONS

- Circle of Security (COS) (https://youtu.be/1wpz8m0BFM8)
- Nurse Family Partnership (NFP)
- Steps toward Enjoyable, Effective Parenting (STEEP)
- Promoting First Relationships
- Sensitivity Coaching
- Video Feedback Intervention



Marvin, R., Cooper, G., Hoffman, K. and Powell, B., 2002. The circle of security project: Attachment-based intervention with caregiver-pre-school child dyads. *Attachment & Human Development*, *4*(1), pp.107-124.

Olds DL, Henderson CR, Kitzman H, Eckenrode J, Cole R, Tatelbaum R. The promise of home visitation: Results of two randomized trials. *J Community Psychol.* 1998;26:5-21.

Erickson MF, Egeland B. The STEEP program: Linking theory and research to practice. *Zero to Three.* Oct/Nov 1999; 20: 11-16.

Kelly JF, Buehlman K, Caldwell K. Training personnel to promote quality parent-child interactions in families who are homeless. *Top Early Child Special Educ.* 2000; 20: 174-185.

Bilszta, J.L., Buist, A.E., Wang, F. and Zulkefli, N.R., 2012. Use of video feedback intervention in an inpatient perinatal psychiatric setting to improve maternal parenting. *Archives of women's mental health*, *15*(4), pp.249-257.

Early Intervention

- Aim is to improve parenting and it's positive effect on the child[1]
- To prevent perinatal MH disorders (where possible)
  - Help mothers stay well by addressing modifiable risks
  - Identify High Risk groups and support them
- Early detection and timely and effective treatment
- Avoid "Omission Bias" in providing care[2]
- Some effects of perinatal MH disorders may not be reversible[1]
- The Key is for a stepped care approach that enables well being focus, access, effective identification, support and intervention.

- Points of Intervention:
  - Pre-pregnancy consultation
  - High Risk Pregnancies
  - Antenatal Groups
  - Universal Screening and follow-up action
  - Make baby the focus of discussion
  - Remember Partners can get depressed too

1. Stein, A., Pearson, R.M., Goodman, S.H., Rapa, E., Rahman, A., McCallum, M., Howard, L.M. and Pariante, C.M., 2014. Effects of perinatal mental disorders on the fetus and child. *The Lancet*, *384*(9956), pp.1800-1819
2. Miller, L.J., 2009. Ethical issues in perinatal mental health. Psychiatric Clinics of North America, 32(2), pp.259-270

Conclusions

- Perinatal Mental Health Disorders are common affecting 1 in 5 mothers
- They have significant impact on mother, fetus/baby, family both short and long term
- Costs to the society is huge economically and through loss of productivity
- They can be easily detected and effectively treated
- Prevention and/or early intervention has moderating effect on the consequences
- Parenting is the key moderator and supporting, and improving this should be the aim
- There has been a encouraging policy shift in Australia and stepped care models can provide effective and timely access to care

Vision of a Stepped Care Model

- Engagement and Education of community about parenting and perinatal MH disorders
- Addressing potential high risk situations with couples and enabling protective factors
- Proactively working with mothers with high risk factors
- Screening, early detection and early intervention
- Access to suite of appropriate (and acceptable) levels of specialist care- outpatient, CL, inpatient and outreach models
- A good multidisciplinary perinatal well-being network
- Integrating Research, Innovation and Education
- Focus should be to improve and enjoy parenting

Dr. Raju Lakshmana

WORKING WITH PARENTS TOWARDS BETTER MENTAL HEALTH

HOME

BEING A PARENT

WHAT IS PND?

DO YOU THINK YOU NEED HELP?

GETTING HELP

SEEKING A CONSULT

FEE STRUCTURE

THANK YOU

WWW.HOLISTICMEDICALSERVICES.COM.AU

Objectives

- Approach to management
- Considerations during pregnancy
- Considerations post-partum
- Resources/ Referrals

Approach

- DO NO HARM
- Keep fetus/ baby in mind: effects on them and effects on parenting
- Lots of controversies and ambiguous information
- Be honest and open
- Involve significant others in decision making
- Don’t rush, provide information and give time
- Discuss, Document and consider second opinion
- Avoid “Omission Bias” in providing care (Miller, L.J., 2009. Ethical issues in perinatal mental health. Psychiatric Clinics of North America, 32(2), pp.259-270)

Questions to consider

- Where to treat?: based on risks
- Do we treat?: Based on severity, morbidity and risks
- How do we treat?: Severity, risks, choices/ preferences, resources
- Multidisciplinary and multipronged approach

General considerations prescribing in pregnancy

- Individual effects of medications depend on the time the foetus is exposed to the medication:
  - Critical period for teratogenic effects is during organogenesis – from day 17-70 after conception
  - Some medications can interfere with functional development and can cause significant effects in the second and third trimester
  - Developmental effects are often not evident until later in life
- Considerations:
  - Is a non-pharmacological treatment available and possibly successful
  - Harm-benefit analysis – prescribing vs not-prescribing
  - Incidence of spontaneous congenital abnormality vs incidence with medications
  - Education, documentation and communication – does the patient understand, have the appropriate people been informed and the documentation made

Considerations of prescribing when breastfeeding

- All psychotropic medications are excreted in breast milk to varying degrees
- Benefits of treating mother must always be weighed against risk of drug exposure in the infant
- Wherever possible:
  - Use the lowest effective dose
  - Avoid polypharmacy
  - Time dosing to avoid feeding at peak plasma/milk levels

Australian categorisation of drugs in pregnancy

Must always remember that the category does NOT imply a hierarchy of safety

Category A = no proven increase in frequency of malformation or harmful effects on foetus in large number of pregnant women

Category B = limited numbers of pregnant woman without evidence of increase in the frequency of malformation or harmful effects on the foetus. Subcategories based on animal studies:

- B1 = Animal studies not showing increased foetal damage
- B2 = Animal studies are inadequate or lacking but available data showing no evidence of increased foetal harm
- B3 = Animal studies have shown increased evidence of foetal damage with uncertain human significance

Category C = Drug which have caused or may be suspected of causing harmful effect on the human foetus without causing malformations – may be reversible

Category D = Drugs which have caused or may be expected to cause increased incidence of malformations or irreversible damage

Category X = Drugs which have such a high risk of causing permanent damage to the foetus that they should not be used in pregnancy or if possibility of pregnancy

Antidepressants

- Cessation of antidepressants during pregnancy is common with relapse rates high
  - 68% patients who cease antidepressants relapse
- Women with a history of depressive illness are at higher risk of further episodes during pregnancy
  - Especially if underlying Bipolar Disorder
- Antidepressants generally considered to be safe in pregnancy – with a few exceptions
  - Mostly considered not to be major teratogens
- All antidepressants considered “Compatible” with breast feeding
- Greater association of following conditions and perinatal depression:
  - Hypertension
  - Pre-eclampsia
  - Post-partum haemorrhage

SSRI

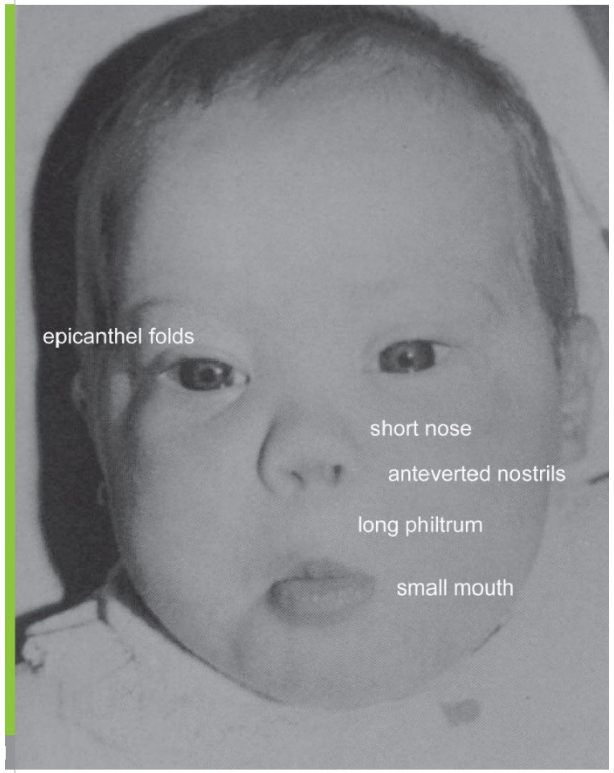
- SSRIs as a general rule considered the safest antidepressants in pregnancy
  - Majority listed by TGA as Category C
- Possible impacts include:
  - Increased persistent pulmonary hypertension of newborn (AR 0.3%)
  - Increased postnatal adaption syndrome, respiratory distress and tremors
- Have been associated with preterm birth, spontaneous abortion and decreased birth weight
  - But rates not seen to exceed those considered associated with depression
- Paroxetine = Category D
  - Specifically associated with cardiac malformations
  - Particularly higher (>25mg/day) dose in first trimester

Bipolar Disorders

- Risk of relapse during pregnancy and postpartum is high if mood stabilisers are discontinued
- One study found that bipolar women euthymic at conception who discontinued mood stabilisers were **twice** as likely to relapse and spent **5 times** as long in relapse than women who continued medications
- Postpartum relapse is up to **8 times more likely in the first month**
- Women with Bipolar are 50% more likely to have:
  - Induction of labour or LSCS
  - Pre-term delivery
  - Small for gestational age neonate
  - Microcephaly

Valproate

- Category D
- Associated with numerous congenital abnormalities – with rate of 1:15
- Risk of neural tube defects is most commonly reported
  - Appears to be dose related increase in risk especially >1000mg daily
- *Foetal Valproate Syndrome* describes a craniofacial phenotype with multiple major malformations, growth deficiency and neurodevelopmental dysfunction
- Breastfeeding “compatible”



Sedatives

- Anxiety and insomnia are commonly seen in pregnancy
- Benzodiazepines = Category C
  - Mixed data on teratogenicity
  - New research indicates higher spontaneous abortions (OR:1.85) (Sheehy O, Zhao J, Bérard A. Association Between Incident Exposure to Benzodiazepines in Early Pregnancy and Risk of Spontaneous Abortion. *JAMA Psychiatry.* 2019;76(9):948–957. doi:10.1001/jamapsychiatry.2019.0963)
- Neonatal syndromes are frequently seen
  - Floppy baby syndrome
  - Neonatal withdrawal syndrome – persisting for as long as 3 months after delivery
- Promethazine (sedating antihistamine) is used for hyperemesis gravidarum so considered a safe option
- There is no evidence to review rapid tranquilisation in pregnancy
  - Judicious use of usual medications is likely to be safe.
- Breastfeeding = “Compatible”

Psychosis

- The risk of perinatal psychosis is 0.1-0.25%
  - But increases to about 50% in women with a history of bipolar disorder
- The rate of psychosis has been seen to increase with childbirth and in greater numbers if underlying mental health concerns
- Postpartum psychosis is a significant problem which can be predicted by psychiatric illness in pregnancy
- All antipsychotics: Category C
- Low doses, slow increases, lowered tolerability
- ECT and rTMS

Conclusion

- Prevent if possible
- Early intervention is effective and efficient
- Always think of the fetus/ baby and it’s needs (parenting)
- Firstly, Do No Harm
- Avoid Omission Bias
- Prescribe using a Risk Benefit Analysis framework
- Give information, support, time and involve significant others
- Document

Perinatal MH Disorders- Psychosocial Treatments

Dr. Raju Lakshmana

Consultant Psychiatrist

Disclosures

- Private Practice- www.holisticmedicalservices.com.au
- Clinical Director of Perinatal MH services @ Mitcham Private Hospital