Getting Ahead of Perinatal Mental Health Problems: An Update on Management in General Practice

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Lake Hume - Albury
An update:

- Background (quick review)
- Mood and anxiety focus
- 2 cases
- Families (infants, fathers)
- Wrap-up

Deloitte 2012 report

<table>
<thead>
<tr>
<th>Illness</th>
<th>Prevalence (%)</th>
<th>New mothers/ fathers</th>
<th>Prevalence (n)</th>
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<tbody>
<tr>
<td>Maternal AND</td>
<td>8.9%</td>
<td>289,335</td>
<td>25,751</td>
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<tr>
<td>Maternal PND</td>
<td>15.7%</td>
<td>289,335</td>
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<td>Paternal AND</td>
<td>5.3%</td>
<td>280,655</td>
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<tr>
<td>Paternal PND</td>
<td>3.6%</td>
<td>280,655</td>
<td>10,104</td>
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Source: Buist and Bilszta 2006; Matthey et al. 2000 and ABS 2010.

Note: The literature presents a wide range of estimates of prevalence rates, commonly taken from screening samples, which are subject to false positive and false negative results. The estimates presented in this table reflect the criteria outlined in section 2.2.

The total number of people with perinatal depression in 2012 was estimated to be 96,156, including 71,177 new mothers and 24,979 new fathers.

Reference: The cost of perinatal depression in Australia FINAL REPORT Post and Antenatal Depression Association
Deloitte Costs Contributors 2012

Chart i: Total estimated economic costs of perinatal depression in Australia in 2012

Source: Deloitte Access Economics calculations.

Prevalence of children having a parent with a prior MH disorder or current MH contact all births and first births, WA 1990-2005

Ref: O’Donnell 2013 MJA
Hospital admissions for principal diagnosis of psychiatric disorders in primiparous mothers, 2001–2010, NSW, AUS

A mother may be admitted to hospital for psychiatric disorders more than once

Xu et al. BMC Women’s Health 2014, 14:119

Parental Mental Health Problems

- Common MH problems: anxiety, depression, alcohol
- Complex MH problems in families
- Persistent, disabling, complex &/or recurrent severe MH problems
- Socially, behavioural or developmentally affected young children or at risk
- Whose role, whose service, which partners?
  (families linked by psychopathology but not clinical care)
Prevalence of Perinatal Depressive and Anxiety Disorders

- **Depression (PND):** 15.7%
- **Anxiety:** At least 14% in postpartum period combining panic disorder, OCD and generalized anxiety disorder.
- By far, the most common serious medical complications of the perinatal period.

Motherhood may not be magical for women suffering with perinatal depression and related problems.
Common Dysphoric Emotional Experiences in New Mothers

- Mood lability—blues and euphoria (pinks).
- Often unanticipated and sometimes overwhelming stress of newborn care: loss of control of one’s time, feeling trapped, “Why did I do this?”
- Heightened anxiety due to hyper-vigilance about the baby’s welfare.
- Delayed feelings of love for the baby.

Diagnosing Perinatal Depression: Hallmark Psychological Symptoms

- Depressive mood, sadness, tearfulness.
- Diminished interest or pleasure in most activities (especially in taking care of the baby).
- Feelings of worthlessness or inappropriate guilt (especially about being an inadequate mother).
- Recurrent thoughts of death or suicide.
Ambiguous Symptoms

- Changes in appetite or weight
- Sleep disruption (however, persistent inability to sleep when the baby is asleep is a common symptom in postpartum depression).
- Persistent fatigue.
- Psychomotor retardation or agitation.
- Diminished subjective perception of ability to think or concentrate: foggy

Specific Symptoms

- Inability to enjoy pregnancy/new baby.
- Panic, especially with fears of unwittingly harming baby or something bad will happen.
- Can’t rest.
- Harm self or foetus or baby or have thoughts of it.
Obstacles to Recognition of Perinatal Mood/Anxiety Disorders

- High expectations of joy & happiness with new baby or expecting: puzzled if dysphoric symptoms arise.
- Attribution of dysphoria to stress, not assessing hallmark symptoms.
- Self blame/"bad mother".
- Lack of knowledge about mood and anxiety disorders.
- Privacy about emotional concerns.
- Stigma
- Peer/professional awareness

Biological Risk Factors for Postpartum Depression

- History of postpartum depression (up to 50% risk).
- History of depression not associated with pregnancy (up to 25% risk).
- Depressive symptoms during pregnancy.
- Family history of mood disorder.
- History of premenstrual dysphoric disorder.
- Postpartum blues.
Do hormones play a role?

- Progesterone and estrogen levels drop precipitously postpartum. Cortisol, thyroid and other large hormonal shifts also occur.
- However, hormone levels and changes in levels do not correlate with mood symptoms.
- But recent research indicates that women who get peripartum depression are more sensitive to hormone fluctuations.

Psychosocial Risk Factors for Perinatal Depression

- Lack of social support: no confidante.
- Poor relationship with the father of the baby.
- Stressful life events.
- Primiparity.
- Adolescence.
- Perfectionistic traits.
Postpartum Anxiety Disorders: Clinical Characteristics

- Panic disorder:
  - Intense fear of harm/harming baby.
  - Panic.
  - Difficulty caring for, leaving baby.

- OCD:
  - Intrusive thoughts/images of grievous harm to baby.
  - Mother sometimes imagines herself inflicting harm.
  - Observations of intrusive parental behaviors.

Effects of Pregnancy on the Natural Course of Anxiety Disorders

- Panic disorder:
  - Increased risk of recurrence or intensification postpartum.

- Obsessive compulsive disorder:
  - Many women with OCD (perhaps around 40%) have initial onset of symptoms during pregnancy or the postpartum period.

- PTSD ie. past trauma (esp. CSA)
- Social Anxiety
Screening tools

National Institutes for Clinical Excellence (NICE)

• 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?

If the woman answers ‘Yes’ to both questions a further question should be asked:

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

Edinburgh Postnatal Depression Scale (EPDS)

In the past seven days:

• I have been able to laugh and see the funny side of things
• I have looked forward with enjoyment to things
• I have blamed myself unnecessarily when things went wrong
• I have been anxious or worried for no good reason
• I have felt scared or panic for no very good reason
• Things have been getting on top of me
• I have been so unhappy that I have had difficulty sleeping
• I have felt sad or miserable
• I have been so unhappy that I have been crying
• The thought of harming myself has occurred to me

Scored 0-30. Scores ≥ 13 associated with 10x likelihood that patient has major depression

Consequences of Untreated Depression

• Woman may not seek prenatal care or follow through on health care recommendations
• May be less responsive to infant, resulting in sub-optimal delayed development
• May cause stress in relationships
• Increased risk for future episodes of depression
• Increased risk of self injury/suicide
• Difficulty or failure in adjustment
Consequences of Untreated Depression/Anxiety for the Infant

- Poor weight gain
- Feeding problems
- Sleep problems
- Poor emotional attachment
- Behavior problems
- Mother may be less attentive to hygiene/safety/immunization

Depression affects how a woman is able to relate to others, including her baby.
Mood Disorders in Pregnancy

- Not necessarily a high risk time for new onset
- Relapse rates of existing disorders are high
Severe Unipolar Depression in Pregnancy

- But....

- In the Cohen et al. study, the overall relapse rate was 43% and ~ 75% of the women had 3+ prior episodes of depression
Relapse of Major Depression when Antidepressants are Discontinued

![Graph showing the proportion of pregnant women remaining euthymic over weeks of gestation.]

- Maintained Rx (n=82)
- Discontinued Rx (n=65)

HR: 5.0 (2.8-9.1)

Risks of Continuing Medication

Weigh risk/impact of relapse vs. Potential risks of medication use

Cohen et al. JAMA 2006;295(5):499-507
Mood Disorders in Pregnancy

Case 1: Sarah
- 29-year-old, married, real estate agent
- Had a depressive episode 2 years ago where she lost interest in work and quit her job, which negatively affected her interpersonal relationships as well
- No evidence of bipolarity, no history of psychosis or safety issues
- You treated her successfully with sertraline, and she has reached remission
- She and her new husband plan to try to become pregnant imminently
- She asks you if this is the right time to discontinue her antidepressant
Back to Sarah

- Is this right time to discontinue her antidepressant?
  - Consider severity/recurrence of depressive illness (attn: to prior pregnancies/postpartum periods and premenstrual symptoms)
  - Consider how quickly/effectively she responds to non-pharmacological and pharmacological treatment
  - Consider other risk factors for poor pregnancy outcomes or relapse (e.g. medical and psychiatric comorbidity, psychosocial)
  - Consider gestational age of patient (i.e. planning vs. 1st trimester)
  - Consider her personal preferences

Possible Plans: Sarah

**Discontinue**
- Monitor for recurrence of illness
- If illness recurs in pregnancy: consider non-pharmacologic and pharmacologic treatment strategies and potentially restart medication
- Plan for prevention of postpartum depression
- No clear evidence for prophylactic re-start of medication postpartum in euthymic women

**Continue**
- Pharmacokinetic changes in pregnancy and at delivery
  - Absorption (watch emesis)
  - Increased hepatic metabolism
- Continue to monitor and plan for prevention of PPD
Other Considerations

1. If she elects to continue:
   - Would you recommend changing to a different antidepressant?
   - Should you reduce her dose or discontinue in 3rd trimester to avoid NAS?

2. What if she had presented already pregnant... at 14 weeks gestation?

Potential risks to the fetus and infant with prenatal exposure to psychotropic medications

- Teratogenicity (Organ malformations)
- Neonatal toxicity (Perinatal syndromes)
- Neonatal withdrawal syndromes.
- Behavioral Teratology (Postnatal behavioral sequelae)
- Lactation and Infant Exposure
Assessing the Safety of Psychotropic Medications in Pregnancy/Lactation-cont

- A considerable body of evidence accumulated over the last 2 decades indicates that fetal/newborn exposure to most classes of psychotropic medication is relatively safe even during the first trimester.
- Mounting evidence that stress during pregnancy, including the stress of untreated severe psychiatric illness, has adverse effects on fetal development.

Potential Risks of Treatment with Psychotropic Medications

- Malformations.
- Behavioral teratogenicity.
- Drug effects on the newborn- toxicity, withdrawal.
- Blood volume changes: Drug levels shift into the sub-therapeutic range during pregnancy or toxic range postpartum.
Potential Risks of Not Treating With Psychotropic Medications

- Depression, other untreated psychiatric disorders during pregnancy are associated with poor obstetric outcomes.
- In utero stress retards fetal growth, may disrupt normal behavioral development.
- Children of mentally ill mothers have more medical, psychological, and cognitive problems.
- Increased risk of recurrence and treatment resistance of illness.

Antidepressants in Pregnancy and Lactation

- SSRIs relatively safe even during 1st trimester except paroxetine (increases birth defect rates).
- SSRIs (especially sertraline, citalopram) and TCAs (especially nortriptyline) relatively safe in breast-feeding. Fluoxetine accumulation, TCA-induced seizures. Venlafaxine accumulates in milk. Insufficient information about newer antidepressants.
- MAOIs associated with growth retardation, congenital malformations.
Clinical Practice Guidelines

Rec 5  Non-directive counselling in the context of home visits can be considered as part of the management of mild to moderate depression for women in the postnatal period.  
Grade C  Section/Page 6.2.2, p41

Rec 6  Cognitive behavioural therapy (CBT) should be considered for treating women with diagnosed mild to moderate depression in the postnatal period.  
B  7.3.1, p44

Rec 7  Interpersonal psychotherapy (IPT) can be considered for treating women with diagnosed mild to moderate depression in the postnatal period.  
C  7.8.3, p45

Rec 8  Psychodynamic therapy can be considered for treating women with diagnosed mild to moderate depression in the postnatal period.  
D  7.8.6, p45
### Clinical Practice Guidelines

**GPP 27** In decision-making about the use of pharmacological treatment in the antenatal period, consideration should be given to the potential risks and benefits to the pregnant woman and fetus of treatment versus non-treatment.

**GPP 28** In decision-making about the use of pharmacological treatment in the postnatal period, this needs to be weighed against minimal possible exposure to the infant during breastfeeding.

**GPP 29** When the risk of birth defects is discussed, women should be provided with a detailed explanation of the baseline, absolute and relative risks to the fetus or infant of pharmacological treatment, as well as the potential impact on the offspring of treatment versus non-treatment.

**GPP 30** If a decision is made to commence or continue antidepressant medication during pregnancy, use of SSRIs can be considered as this is the antidepressant category about which most is known. The current evidence on SSRIs shows no consistent pattern of additional risk of birth defects. While the safety of TCAs is supported by a lesser body of evidence, they can also be considered, especially if they have been effective previously.

**GPP 31** If a decision is made to discontinue or decrease antidepressant medication, it is important to gradually taper the dose, closely monitor and have a plan to identify relapse early.

**GPP 32** Withdrawal symptoms of antidepressants need to be distinguished from symptoms of relapse, therefore close monitoring post discontinuation/reduction is essential. Expert psychiatric advice should be sought if necessary.

**GPP 33** Guidelines for the use of antidepressants in the general population should be consulted (see Appendix 6).
Postpartum mood disorders

- Risk appears to be substantially higher than in pregnancy both for new onset and recurrent mood disorders
Case 2-Mrs. C

- A 35 year old teacher
- Brought to the office by her husband of 10 years
- He has noticed that since the birth of their one month old daughter, Mrs. C. has not been her normal self-he is worried
- Mrs. C starts to cry after you ask her about the baby
  - She feels overwhelmed, a bad mother, and especially guilty about having had a baby, not sleeping
  - Most of the time she is irritable and anxious
- Personal history of abusive (psychological) mother
- You note she is tearful, frustrated, poor mother-infant interaction

Case 2 -commentary

- EPDS=20, PHQ2= 6
- Mrs. C likely has postpartum mood disorder
- Important to discuss findings with her and her husband
- Make urgent and comprehensive response (referral support)
- Consider using SSRI
- Family support: flag social emergency
- New service referral(?)
- Referral to support group
- Early follow up
Postpartum Depression Management

- **Lifestyle and Social Support**: Ensure adequate sleep, engage social supports
- **Psychotherapy**: For mild and moderate depression, evidence for interpersonal psychotherapy and cognitive behaviour therapy (group and individual)
- **Medication**: Same principles as non-postpartum
  - all antidepressant medications pass into breastmilk at < 10% of maternal dose;
  - use of benzodiazepines is NOT an absolute contraindication for breastfeeding with healthy full-term infant
- **Repair relationship functioning**

Clinical Practice Guidelines

| GPP 39 | Women with healthy full-term infants who plan to breastfeed can be advised that SSRIs are not contraindicated. | 8.4.1, p55 |
Clinical Practice Guidelines

| GPP 17  | Assessing the mother–infant interaction should be an integral part of the care of women in the postnatal period. | 4.1, p29 |
| GPP 18  | Where significant difficulties are observed with the mother–infant interaction and/or there is concern about the mother’s mental health, the risk of harm to the infant should be assessed. | 4.1, p30 |

Effective Interventions to Improve Childrens’ Mental Health

- Treat parental depression:
  - mo’s in STAR-D (age > 7) (Pilowsky DJ et al., 2008)
- Add treatment of dyad for infants
- Meta-analysis demonstrates MI can be reduced by 40% in preventive interventions (Siegenthaler et al., 2012)
- Let’s Talk (2-3 sessions)
- Family focus (5-6 sessions) (Beardslee et al., 2011)
- PND groups + individual + infant
Bipolar Disorder Management

1. **Prevention**: social support, sleep protection, some advise longer stay with rooming out of baby for high risk mothers but evidence limited for this strategy

2. **Safety Assessment**: mother, baby (+/- other kids)

3. **Treatment**: based on nature and severity of illness
   - **Psychotherapy**: Strongest evidence for Interpersonal Therapy (IPT) where focus is on role transition to parenthood and improving communication abilities and social support
   - **Psychotropic medication**: as indicated, consider passage into breastmilk and risk of toxicity
   - **Somatic Therapies**
“Rules of thumb” for use in designing a clinical treatment plan for pregnant women with psychiatric illness

**Intensive Management**

- **When to refer (examples)?**
  - Diagnostic clarity
  - Need for specialized psychotherapy, DBT, Trauma focussed CBT
  - Failure to respond to first-line antidepressant medication treatment
  - Postpartum psychosis - a psychiatric emergency
    - Do not leave mother unsupervised
    - Send to emergency department (hospital) for assessment and treatment – Form 1
  - DSH, multiple hospital admissions: BPD?
  - Manage risk (to mother, baby, others)
One in 6 babies
Mental Disorder and Families

- 1 million Australian children live with a parent who has a mental illness (estimate)
- Mental illness:
  - 2-4 times higher
  - 40-70 %
- Social, developmental, educational and emotional difficulties
  (Beardslee, Solantaus, Morgan, Gladstone & Kowalenko, 2012)
- Paternal and Maternal Depression (Fletcher et al 2011)
One in 6

Parenting Theory and Attachment (dyads)

Attachment & Exploration
- Comfort
- Exploration
- Validation in mother-infant dyads
- More verbal
- Calms
- Closer proximity

Activation
- Stimulation of risk taking (excites)
- Control (limit setting)
- More physical
- Unpredictable

Triadic relationships – a theory & assessment
Parental perceptions of exciting-risk taking

Fathers’ Substance Abuse (alcohol and other drugs)

- More behavioural disorders (esp boys) Loukas et al., (2001)
- More difficulties with other drugs vs alcohol Kelley ML et al., (2004)
- More psychosocial disadvantage with other drugs
- Fathers (with dependence) report drinking more after interacting with children with difficult temperament Loukas et al., (2003)
Fathers involvement and children’s developmental outcomes

Positive influence of father engagement on social, behavioural & developmental outcomes (meta-analysis of 24 studies)
(Sarkadi, A et al., 2008)

= Type of engagement unclear

Parents living with Psychotic Illness (2010)

WOMEN
52% with children
23% with dependent children

MEN
25.9% with children
5.5% with dependent children

PARENTS with a psychotic illness
Cross Cultural Factors Matter

Why does it matter?

- Transition for families and stresses families (biological and psychological)
- Vulnerable and in contact with health services
- Foundation for resilience, emotional regulation and social functioning
- Opportunity in crisis and for advancing maturity
- Early intervention, early in life
Questions/Discussion

References

• Tresillian
  https://www.tresillian.org.au/

• Perinatal Clinical Practice Guidelines beyondblue

• Management of Psychotropic Drugs during Pregnancy
  http://www.bmj.com/content/352/bmj.h5918

• National clinical guidelines for the management of drug use during pregnancy, birth and the early development years of the newborn