Modern Management of Perinatal Psychiatric Disorders

For James and Richard
Carol Henshaw

For Karin, our three daughters Christina, Ann-Marie and Susanne, granddaughter Suzannah and grandson Joshua
John Cox

For Flip
Joanne Barton

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2nd edition

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RCPsych Publications

RCPsych Publications is an imprint of the Royal College of Psychiatrists,
21 Prescot Street, London E1 8BB
http://www.rcpsych.ac.uk

British Library Cataloguing-in-Publication Data.
A catalogue record for this book is available from the British Library.
ISBN 978 1 909726 77 2

Distributed in North America by Publishers Storage and Shipping Company.

The Royal College of Psychiatrists is a charity registered in England and Wales (228636) and in Scotland (SC038369).

Printed by Bell & Bain Limited, Glasgow, UK.

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Abbreviations

ADHD	attention-deficit hyperactivity disorder
ART	assisted reproductive technology
BDI	Beck Depression Inventory
BDZ	benzodiazepine
CBT	cognitive–behavioural therapy
CEMD	Confidential Enquiry into Maternal Deaths
CNS	central nervous system
CSA	child sexual abuse
DSM	*Diagnostic and Statistical Manual of Mental Disorders*
ECT	electroconvulsive therapy
EDNOS	eating disorder not otherwise specified
EPDS	Edinburgh Postnatal Depression Scale
FASD	fetal alcohol spectrum disorder
GAD	generalised anxiety disorder
GP	general practitioner
HPA	hypothalamic–pituitary–adrenal
HRSD	Hamilton Rating Scale for Depression
ICD	International Classification of Diseases
IPT	interpersonal psychotherapy
LSD	lysergic acid diethylamide
MAOI	monoamine oxidase inhibitor
MDI	Mental Developmental Index
MDMA	methylenedioxymethamphetamine
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
NICU	neonatal intensive care unit

NRT	nicotine replacement therapy
OCD	obsessive–compulsive disorder
O-DV	*O*-methyldesvenlafaxine
OR	odds ratio
PDSS	Postpartum Depression Screening Scale
PMDD	premenstrual dysphoric disorder
PNAS	poor neonatal adaptation syndrome
PTSD	post-traumatic stress disorder
RCT	randomised controlled trial
RR	relative risk
SNRI	serotonin–noradrenaline reuptake inhibitor
SSRI	selective serotonin reuptake inhibitor
STAI	Spielberger State–Trait Anxiety Inventory
TCA	tricyclic antidepressant
UKTIS	UK Teratology Information Service
VTE	venous thromboembolism
WHO	World Health Organization
Y-BOCS	Yale–Brown Obsessive Compulsive Scale

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Preface

The impetus to write this book over 5 years ago came from our concern, as clinicians, researchers and educators, that trainee psychiatrists required access to knowledge about the diagnosis and management of perinatal mental disorder which was not then readily available. We also had in mind general practitioners and obstetricians, and readers from other professional backgrounds such as psychology, nursing and management.

In this second edition we have rewritten and updated several chapters to reflect current practice and new knowledge in this now rapidly expanding field. We hope that readers from low and middle-income countries, where psychiatrists are few and far between, will find our approach, and the studies cited, helpful to their needs.

The development of active and informed advocacy groups in most regions of the world is a powerful synchrony of patient experience and professional expertise. We hope that this edition, although not including many clinical narratives, will nevertheless be of interest to parents and their carers.

Maternal mental disorder remains a risk factor for stunted growth and impairment of cognitive development in children throughout the world (Stein, 2014). Suicide remains a leading cause of maternal death in the UK (Knight *et al*, 2014). It is essential that clinicians in primary and secondary care are aware of these disabling conditions, and that women who suffer from them, or are at risk of doing so, are identified, assessed and treated.

It remains essential in our experience to approach the management of these women from a biopsychosocial perspective, and for health professionals to be fully aware of the sociocultural context and the 'meaning' of the illness for the mother and her family. The optimal management of parents with childbearing-related mental disorder, and of their developing relationship with their baby, requires clinical judgement of a high order. Psychiatry is an art and a science, and perinatal psychiatry is a person-centred, relationship-based specialty – and in this regard sets an example for the rest of medicine.

Our hope is that readers of this book will be encouraged to develop these broad clinical skills, and to hold together science and values – as well as the body, mind and spirit.

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Acknowledgements

We wish to thank Ilana Crome and Khaled Ismail for their help in writing Chapter 5 in the first edition, and Margaret Oates for her Foreword. Karin Cox has helped greatly over the years with research and writing. We are much indebted to our spouses and families for tolerating our labours – and especial thanks to all those parents and children who trusted us with their care and continue to inspire our work.

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Foreword

This book is a testament to the increasing recognition that maternal mental health problems are the core business of both psychiatry and maternity care.

Perinatal psychiatry is now the internationally accepted term for conditions complicating pregnancy and the postpartum year. These include not only new-onset conditions following delivery, such as postnatal depression and puerperal psychosis, but also pre-existing conditions which may relapse, recur or continue during pregnancy and the postpartum period. It is concerned not only with the medical and psychosocial management of the mother, but also the impact of the disorder and its treatments on the developing infant before and after birth. Although in the UK, perinatal psychiatry is a subspecialty of adult psychiatry; it overlaps and shares common goals with child psychiatry and those concerned with infant development.

Why is perinatal psychiatry so important, and why has it achieved such recent prominence in national policy and practice guidelines? Postpartum psychiatric disorders have long been of great interest to researchers. Childbirth offers a unique research paradigm: a clearly defined cohort, and a mixture of neuroendocrine, psychosocial, anthropological, sociological and epidemiological factors which can be studied across time and across cultures, of interest to psychiatrists, obstetricians, psychologists and social scientists, and to adult and child workers. It poses and answers questions which are not only relevant to this life event but also can inform the aetiology and treatment of disorders, particularly affective disorders, at other times.

Although there has been prominent research interest in perinatal psychiatric disorders for over 40 years, with individual clinical centres of excellence, the provision of specialised services is patchy, inequitable and, at a national level, inadequate.

Over the past 10 years there has been an improvement in both quality and extent of the provision of specialised perinatal services. There are 18 mother and baby units in the UK, all meeting a single national service specification with common quality standards and criteria for access. There are at least 20 comprehensive community perinatal psychiatric teams, some linked with mother and baby units; this number is increasing, and they too operate to

common service specifications and quality standards. Despite this, there is still a national shortfall of mother and baby unit beds, with many women being separated from their infants and admitted to general adult wards, and large areas of the UK where pregnant and postpartum women with mental health problems are cared for by general services rather than specialised services.

The need for specialised perinatal services, mother and baby units, community teams and maternity liaison services is underpinned by a number of factors. Pregnancy and childbirth are associated with considerable psychiatric morbidity. A small but significant number of women will develop a profound psychotic illness in the early weeks following childbirth, requiring specialist skills and resources for their and their infant's proper care. Although the number is small, it represents a substantial increase in the risk of developing a psychotic illness following childbirth compared to other times. A larger number of women will develop a severe non-psychotic affective disorder, and an even larger number will develop the mild-to-moderate affective disorder popularly known as postnatal depression. Overall, at least 10% of delivered women will suffer from a psychiatric disorder following childbirth. The more severe conditions will require the attention of specialised mental health services. The less severe conditions, while probably no more common than at other times, pose a major public health problem, with chronic maternal depression – particularly if associated with socioeconomic adversity – having adverse effects on infant and child development. The perinatal period is also very important because of the risk of recurrence in women with pre-existing serious mental illness, particularly bipolar disorder. Childbirth is unique in psychiatry as a major provoker of mental illness that comes with 9 months warning. The perinatal period poses particular problems for the management of psychiatric disorders. Many psychotropic medications, particularly mood stabilisers, are problematic in pregnancy. Acute psychotic episodes in pregnancy compromise maternal and infant health. The distinctive clinical presentation, rapid onset and deterioration can demand a different response from psychiatric services than at other times. Throughout the perinatal period, psychiatric professionals have to deal with two patients, both mother and infant.

Pregnancy and the early postpartum period is exceptional in the human lifespan for its level of surveillance by health professionals. This provides an opportunity not only for the early detection and prompt treatment of those who are ill, but also for the identification in early pregnancy of those at risk of developing an illness following delivery, and for secondary and perhaps primary prevention.

The UK Confidential Enquiry into Maternal Deaths

Most of the UK national policies for perinatal mental health have been strongly influenced by the UK maternal mortality enquiries over the past

4 years. These reveal that suicide in particular, and psychiatric causes of maternal deaths in general, are a leading cause of maternal mortality. This is also likely to be true internationally. It is generally accepted that maternal mortality is the 'tip of the iceberg' and it is therefore reasonable to assume that psychiatric disorder is also a leading cause of maternal morbidity.

The UK Confidential Enquiry into Maternal Deaths (CEMD) combines both a maternal mortality surveillance and quantitative data analysis with an inquiry into individual cases' descriptions of the pathway of care and circumstances that were associated with an individual death. This combination of methods allows for the identification of themes and factors associated with poor outcomes, which in turn has led to the development of practice guidelines with demonstrable impact on the quality of maternity care. In addition, it allows for the emergence of new themes which reflect not only changes in reproductive epidemiology and technology (for example, increasing maternal age, rise in Caesarean sections, *in vitro* fertilisation) but also rapid societal changes such as the impact of asylum seekers and immigrants.

For the purposes of international comparison, it is important to understand how maternal mortality data are expressed. The maternal mortality rate refers to maternal deaths from 24 weeks of pregnancy to 42 days post-delivery. The causes are defined as direct (for example, haemorrhage, pre-eclampsia) and indirect (for example, pregnancy-exacerbated conditions, including suicide). The maternal mortality ratio is the number of maternal deaths compared to the number of births. ICD-10 pregnancy-related deaths are all deaths which occur during pregnancy and the postpartum year. The UK CEMD includes all deaths up to 1 year, but describe the data in such a way as to allow international comparison.

With each Enquiry, the case ascertainment increases and is generally regarded as being more complete than in other countries. This factor needs to be taken into account when comparing findings from the UK with other countries. Since 1997, case ascertainment has been enhanced by an Office of National Statistics linkage study, which identifies maternal deaths not reported directly to the Enquiry. These deaths have been, in the majority, late indirect and coincidental deaths, but have included a substantial number of suicides.

Over the past 20 years, suicide has remained a leading cause of maternal death. The numbers of maternal deaths due to suicide has not significantly changed, nor have their characteristics.

Over half of all maternal suicides were suffering from a serious mental illness (including postpartum psychosis). Half of these illnesses were occurring for the first time and half were a recurrence of a previous illness. These illnesses characteristically began in the early days and weeks following delivery and deteriorated very rapidly. All of the mothers suffering from serious mental illness were in contact with general adult psychiatric services at the time of their death. Half had a previous psychiatric history

of serious mental illness and previous contact with psychiatric services. In the main, this was for serious affective disorder, including bipolar disorder and affective psychoses. In very few cases was this risk accurately identified at the booking clinic, and in even fewer was a management plan put in place. The apparent lack of awareness of the risk of recurrence of a serious affective disorder following childbirth was found not just in maternity and primary care services but also within mental health services.

The majority of maternal suicides were older, married or in stable cohabitation, employed and educated. This was particularly true of the women who were suffering from serious illness. The majority of women had been well in pregnancy, and many had been well for years previously, having fully recovered from a previous episode of serious illness. Because of their social characteristics and their prolonged period of well-being, these women would not have been recognised as 'vulnerable'. This serves as a reminder that serious illness can affect those in comfortable circumstances with no obvious personal or social problems.

Throughout the Enquiries it has been noted that midwives did not obtain or were not given information about a woman's previous history by the general practitioner or indeed by psychiatric services.

Over the past 20 years, very few mothers who died by suicide had been cared for by specialised perinatal psychiatric services, and even fewer had been admitted to a mother and baby unit – and those who had been admitted to a mother and baby unit died after their care had been taken over by general adult services. It is clear that in the majority of cases, the non-specialised services had not adapted to the maternity context and to the distinctive features of postpartum illness. They often responded too slowly, did not consider admission and underestimated the risk and severity of the condition. More recently it has been noted that the majority of maternal suicides suffered from discontinuity of care, receiving care from multiple psychiatric teams and mental health professionals.

The recommendations of the CEMD therefore remain that women should be asked at early pregnancy assessment for a previous psychiatric history and those with a history of serious mental illness should have a plan in place for the management of that risk. All women with serious mental illness in late pregnancy and the postpartum period should be managed by specialised perinatal psychiatric teams and, if admission is necessary, be admitted to a specialised mother and baby unit. In addition, the past two Enquiries recommend in their 'top 10 recommendations' that women with serious mental illness should be counselled prior to conception about the risk they face associated with pregnancy. Sadly, a constant finding of the CEMD since 1994 has been the violent method of suicide. In contrast to the method of female suicide at other times, 80% of maternal suicides used violent methods. The most common was hanging, followed by jumping from a height. Very few women died from an intentional overdose of prescribed or over-the-counter medication.

Suicide is not the only psychiatric cause of maternal death. Women also died from intentional or accidental overdoses of recreational drugs. A substantial number of women either died from medical conditions that were the consequence of their substance misuse exacerbated by pregnancy, or died because their psychiatric condition led to their medical conditions being missed or misattributed to psychiatric causes. These findings too have been constant over the past 20 years. A worrying theme to emerge from the Enquiries is the significant contribution to overall maternal mortality of substance misuse. Ten per cent of all maternal deaths occurred in substance misusers, and approximately half of all psychiatric deaths. Substance misuse was associated with avoiding antenatal care, high rates of removal of the infant into the care of local authorities and the subsequent absence of both psychiatric and maternity care for the mother. Very few of these women had had specialist care from drug addiction services during their pregnancies. This has led to the additional recommendations that specialised 'one-stop shop' services for pregnant substance misusers are provided, nested within the maternity services, with rapid access and active outreach as a principle of service provision.

The distinctive nature of perinatal psychiatric conditions and their consequences for the infant, as well as for mothers' future mental health, justify educating all those involved in the care of childbearing women and the provision of specialised services for those who are seriously mentally ill. If all psychiatrists discussed with their patients the implications of their conditions and treatments for pregnancy, if all women at risk of serious mental illness following childbirth had proactive management plans in place, and if those who became ill were treated by specialised services, then it is likely that there could be a reduction in maternal mortality and morbidity from psychiatric causes and an improvement in infant mental health. However, despite the increase in specialised service provision and the public profile of perinatal mental health problems, it sadly remains true that maternal suicide is not decreasing and many more suicides were avoidable.

Margaret Oates OBE

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