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.

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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 more than 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

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.

Table 1

delivery and immunological[1] and genetic factors[2] 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 more than 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

