MENTAL ILLNESS & Antenatal care

Most women negotiate the transition through pregnancy, childbirth and motherhood without significant emotional disturbance, however for over 15 per cent of women this experience is tarnished by mental illness. For many the antenatal and/or postpartum period signals the onset of a mental disorder, triggers the recurrence of a pre-existing disorder, or is complicated by a chronic mental illness. In effect, a woman is up to 20 times more likely to be admitted to a psychiatric unit during the first three months postpartum than at any equivalent time prior to conception.[1]

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Knowledge of this increased risk, and the fact that women are generally in frequent contact with health professionals during this time offers us a unique opportunity to work preventatively and act therapeutically should this be necessary. The belief that pregnancy protects women from mental illness reflects community expectation rather than medical reality.[2] Early detection of mental illness during pregnancy is critical because it can adversely affect birth and maternal outcomes, neonatal health and, if left untreated, can persist after birth.

Mental illness and obstetric outcomes

Antenatal mental illness has not received anywhere near as much attention as postpartum illness despite it being one of the most accurate predictors of postpartum illness.[3] Furthermore, it is now clear that antenatal mental illness predicts an increase in adverse outcomes for both mother and child. A substantial number of women treated in obstetrics have unrecognised and untreated psychiatric disorders and substance abuse.[4] A recent study found that approximately 20 per cent of obstetric/gynaecology outpatients (N=3000) met criteria for psychiatric diagnoses, and 77 per cent of this group were not recognised by their treating practitioner.[5] This finding is particularly concerning as it has been shown that psychiatric disorders are a leading cause of indirect maternal death and morbidity. In Australia, during the period 1997–1999, psychiatric causes resulted in more maternal deaths than either thromboembolism or severe hypertension.[6]

Mental illness and fetal outcomes

Mental illness during pregnancy has been associated with poor attendance at antenatal clinics and delayed detection of pathology,[7] substance abuse, low birth weight, small for gestational age and preterm delivery,[8,9] smaller head circumference,[10] placental abnormalities and antepartum haemorrhages,[11] lower APGAR scores,[12] newborn inconsolability and excessive crying,[13] decreased use of paediatric care after birth including missed immunisations and well-child visits and possibly increased rates of instrumental and caesarean section delivery. Prenatal anxiety may have lasting effects on HPA axis functioning in the child and this may constitute a mechanism for an increased vulnerability to psychopathology later in life.[14, 15] It is also now well recognised that postnatal depression, that frequently has its onset antenatally, can result in adverse behavioural, emotional and cognitive outcomes for children.[16] Similarly, schizophrenic illnesses have also been associated with disturbances or mother-infant interactions and negative developmental outcomes.[17,18]

Identification of mental illness in pregnancy

It is important that we do not medicalise the normal adjustment processes associated with pregnancy and motherhood, whilst at the same time not miss those who are mentally unwell and in need of treatment. Consideration of a pregnant woman's psychosocial circumstances and mental state should be a routine part of any initial antenatal assessment and vigilance maintained throughout pregnancy in order to detect the emergence of mental illness.

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Important psychiatric conditions that need to be considered during any antenatal assessment procedure include:

- disorders of adjustment with depressed and/or anxious mood;
- anxiety disorders (eg, generalised anxiety disorder, obsessive compulsive disorder, panic disorder);
- psychotic disorders (eg, schizophrenia, schizoaffective disorder);
- mood disorders (eg, major depression, bipolar affective disorder);
- eating disorders (anorexia nervosa and bulimia nervosa);
- substance abuse disorders;
- personality disorders.

Whilst most adjustment related disorders are mild and self-limiting they can progress and evolve into significant depression and anxiety disorders *per se*. The greatest predictor of childbirth-associated mental illness is a past history of childbirth-associated mental illness. At the same time a number of conditions are known to be prone to perinatal relapse or deterioration. Psychotic disorders such as bipolar affective disorder and schizophrenia possess a perinatal relapse risk of 30-50 per cent. Thus, preventative measures need to be taken during pregnancy.

Management of mental illness in pregnancy

Active management involves:

- early detection of those women who are either unwell or at-risk;
- referral to specialist psychiatric services;
- increased frequency of obstetric review;
- establishment of a psychosocial safety net;
- psychotherapy (whether it be supportive, psychodynamic or other);
- consideration of pharmacotherapy;
- close liaison between health care providers.

Early detection of mental illness involves taking a detailed psychosocial history and performing a mental state examination. Particular attention needs to be paid to women who display or reveal:

- current emotional distress;
- past history of mental illness;
- previous episode of suicide attempt or self-harm;
- family history of mental illness;
- recent deterioration in psychosocial functioning;
- poor marital relationship or separation;
- previous or current domestic violence;
- involvement of child protective services;
- substance abuse;
- late presentation for antenatal care;
- poor antenatal attendance or non-compliance;
- prolonged period of infertility prior to conception;
- lower socio-economic status;
- ambivalence or negative attitude toward the maternal role;
- pattern of maladaption to change in developmental tasks;
- absence of extended family / social isolation;
- stressful life events.

Psychiatric referral

A low threshold for referral to psychiatric services should be adopted given the significant possibility of adverse outcomes for both mother and child.

Possibilities for referral include: community mental health clinics, obstetric hospital psychiatric liaison services, community assessment and treatment teams, specialist mother and baby units, and private psychiatrists. A common error is to refer a mother to early parenting centres that lack the necessary skills to intervene when mental illness is the primary problem.

Safety net

Establishment of a safety net involves engagement of significant others and professional services in the management plans. This involves partners, family, friends, social workers, family support services, infant welfare centres, psychiatric case managers etc. These people are usually well placed to assist in the detection of relapse or deterioration.

Pharmacotherapy

Pharmacotherapy should only be commenced after careful consideration is given to the potential risks and benefits to both mother and child and the issue discussed openly and fully with both the woman and her partner. Specialist psychiatric opinion should be sought whenever a woman takes psychotropic medication during pregnancy to ensure that the treatment is appropriate and that more suitable alternatives have been considered. Given that many psychotropic medications have been associated with neonatal withdrawal and sedation states, it is prudent to involve a paediatrician early where possible.

Collaborative care

Much can be done to reduce barriers to effective psychiatric care in the obstetric setting, implement illness management, identify those pregnant women at-risk, effect treatment and improve outcomes for both mother and child. Close liaison relationships need to be established between the participating obstetrician, midwives, general practitioner, maternal and child health nurse, paediatrician, professional support services and psychiatric services. The key to such success involves the recognition that obstetrics has much to gain from psychiatry, and psychiatry has much to learn from obstetrics. A fruitful relationship between the disciplines can only assist the mothers and babies who trust us with their care.

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available soon:

postnatal depression CPD activity

RANZCOG and the RACGP are working together to develop an activity on postnatal depression for which CPD points will be available.

Information will be posted on the RANZCOG website (www.ranzcog.edu.au/cpd) closer to the release date.

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