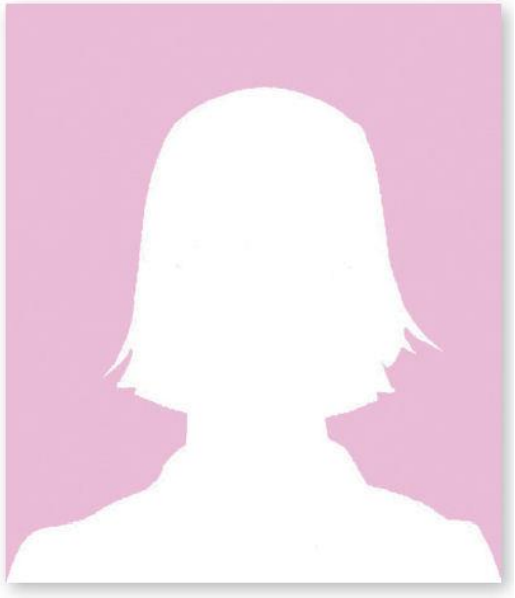


Dr Liz MacDonald

Psychiatrist

Mothers & Babies Service, Canterbury District Health Board, Christchurch

Friday, August 12, 2016 (Room 4)

14:00 - 14:55 WS #27: Perinatal Anxiety and Stress: What a GP Needs to Know

15:05 - 16:00 WS #37: Perinatal Anxiety and Stress: What a GP Needs to Know (Repeated)

Perinatal Anxiety and Stress

DR LIZ MACDONALD
CONSULTANT PSYCHIATRIST/CLINICAL HEAD
MOTHER AND BABY SERVICE
PRINCESS MARGARET HOSPITAL
CHRISTCHURCH

Perinatal Anxiety and Depression Aotearoa

Vision:

To eliminate stigma around perinatal mental health in New Zealand by championing awareness and facilitating best practice in perinatal mental health and wellbeing to ensure all families have access to appropriate information and support

Mission:

- **Supporting and linking the service providers who work with young families**
- **Advocacy and awareness**
- **Resources and professional development**
- **Support and encouragement for new parents**

Mothers and Babies Service
Regional Perinatal and Infant Service

- Assessment, treatment of mothers and babies with complex moderate to severe mental illness as OP or IP
- Preconception counselling /phone prescribing advice
- Bonding and Attachment
- Multidisciplinary Team inc 0.2 paed
- OP Intake: Second trimester to 12 months postpartum
- 5/6 IP beds for South Island for mothers and babies
- Accessed via referral from GP/Mental health service/CWH or regional MHS
- Regional – consultation/ admission/ education

Aims for today

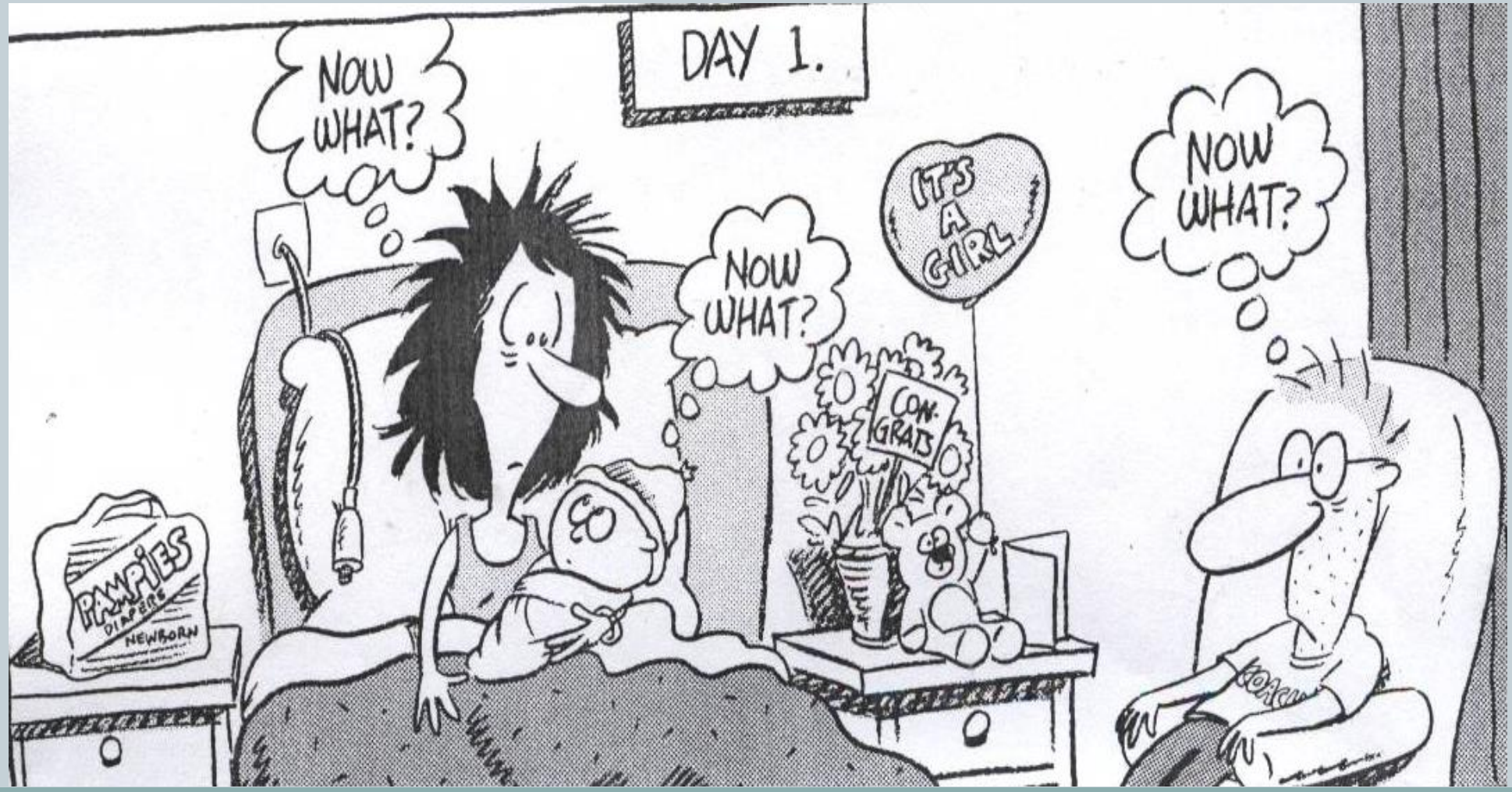
- “Normal” stress and anxiety in pregnancy
- Why is perinatal mental health important?
- Anxiety and depression Who can be managed in primary care?
- Non-pharmacological interventions
- What medications to use and when?
- When to refer?
- Bipolar disorder

Normal Pregnancy and Stress

- Pregnancy is *change*
  - Changes in
    - Body
    - Relationships
    - Roles and Identity
    - Perspective on the world

Anxiety tends to be high in pregnancy

Adjustment to pregnancy

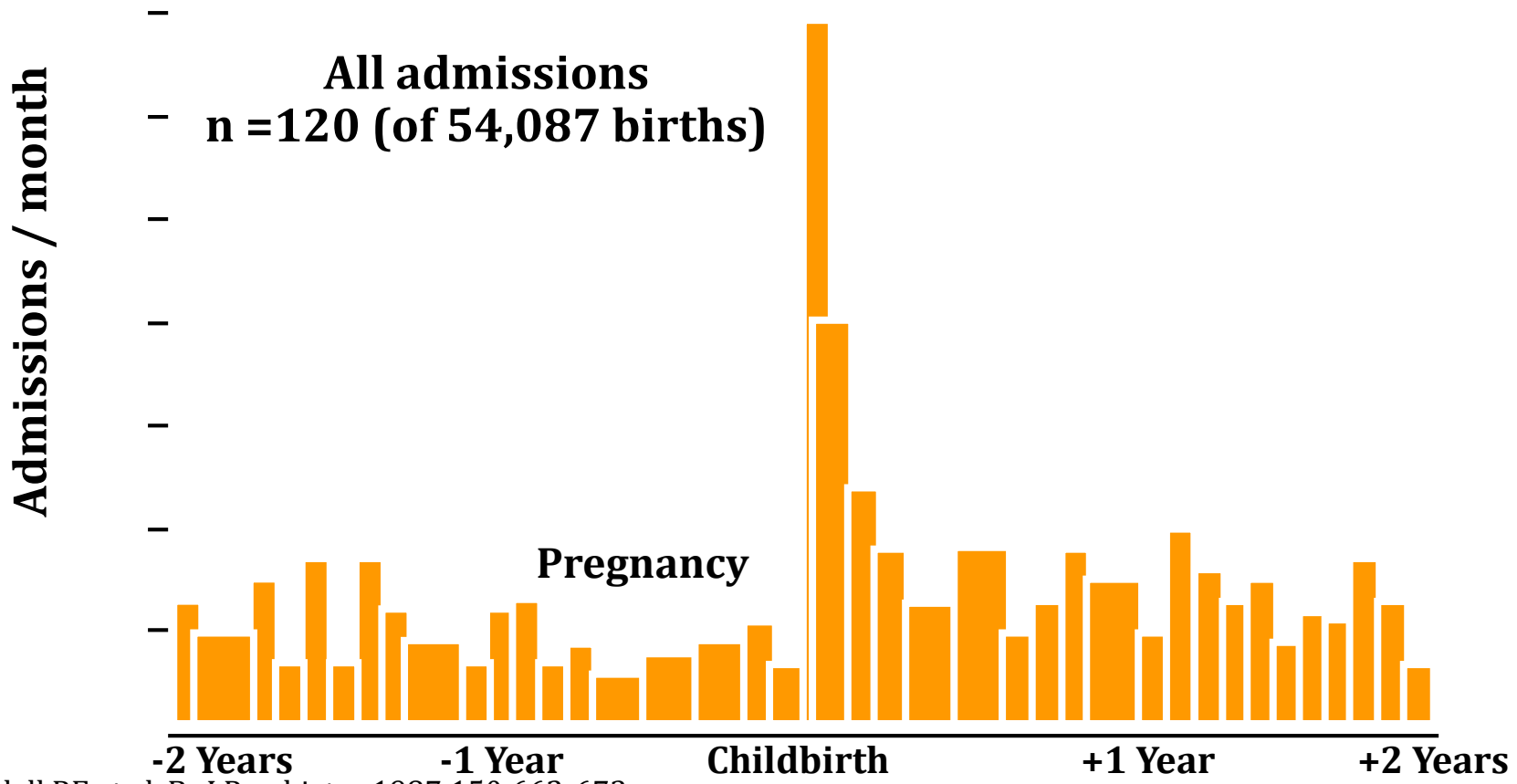


Up to 20% of women will develop a mental illness around pregnancy and postpartum

Why is perinatal mental health important..

- Pregnancy is NOT protective
- All mental health disorders can present during pregnancy and postpartum.
- Depression and anxiety are common during pregnancy and postpartum.
- Beware term ‘Postnatal Depression’
- Important prescribing issues
- Suicide is the leading cause of maternal death in NZ
- The risk of suffering a psychiatric illness is higher after childbirth than at any other stage of life

Psychiatric Admissions in the 2 Years Preceding & Following Childbirth



Kendall RE et al. Br J Psychiatry 1987;150:662-673.
Grof P et al. J of Affect Disorders 2000;61:31-39.
Viguera AC, et al. Can J Psych 2002;47:426-436.

Specific Disorders

- Postnatal depression 10-15%
- Antenatal depression 10%
- Anxiety 15%
- Serious postpartum disorder 2-4% (psychosis 0.5%)
- PTSD 1.5-6%
- Panic disorder/OCD/tokophobia 5-10%
- Personality disorders 15-20%
- Eating disorders

Who is at risk of depression and anxiety?

- History Depression/Anxiety esp PP
- Adverse events and trauma
- Difficult interpersonal relationships/Lack of social support/single
- Poor relationship with own mother
- Young age, DV, low income
- Infant Temperament/ colic/ reflux
- Personality Traits (perfectionist, avoidant, anxious, self-critical)
- Fathers as well!

Presentations to GP

- Pregnancy test
- Medication advice
- 6 week check
- “I think my baby’s got reflux”
- What else?

Case scenario

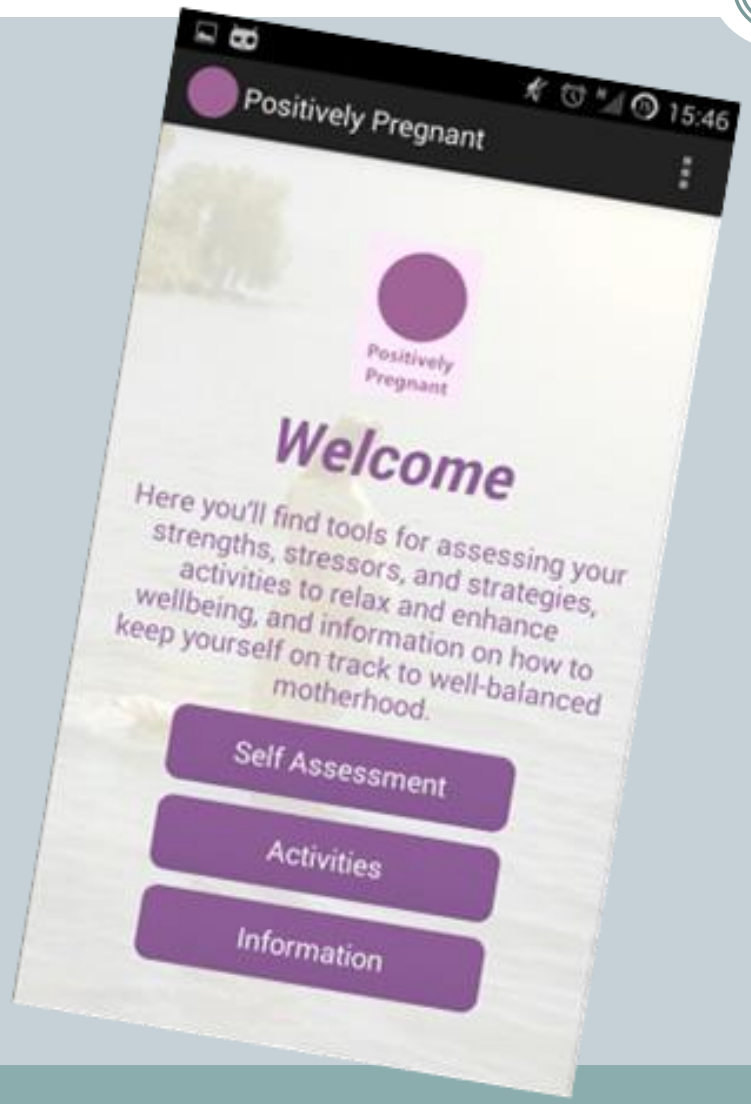
- Sarah is a 26 yr old married pakeha woman 20 weeks pregnant
- Working accountant F/T
- Moving house in 2 weeks
- Grandmothers ‘circling’
- Anxious, highly strung
- GI complaints
- Presents today as tearful and fragile

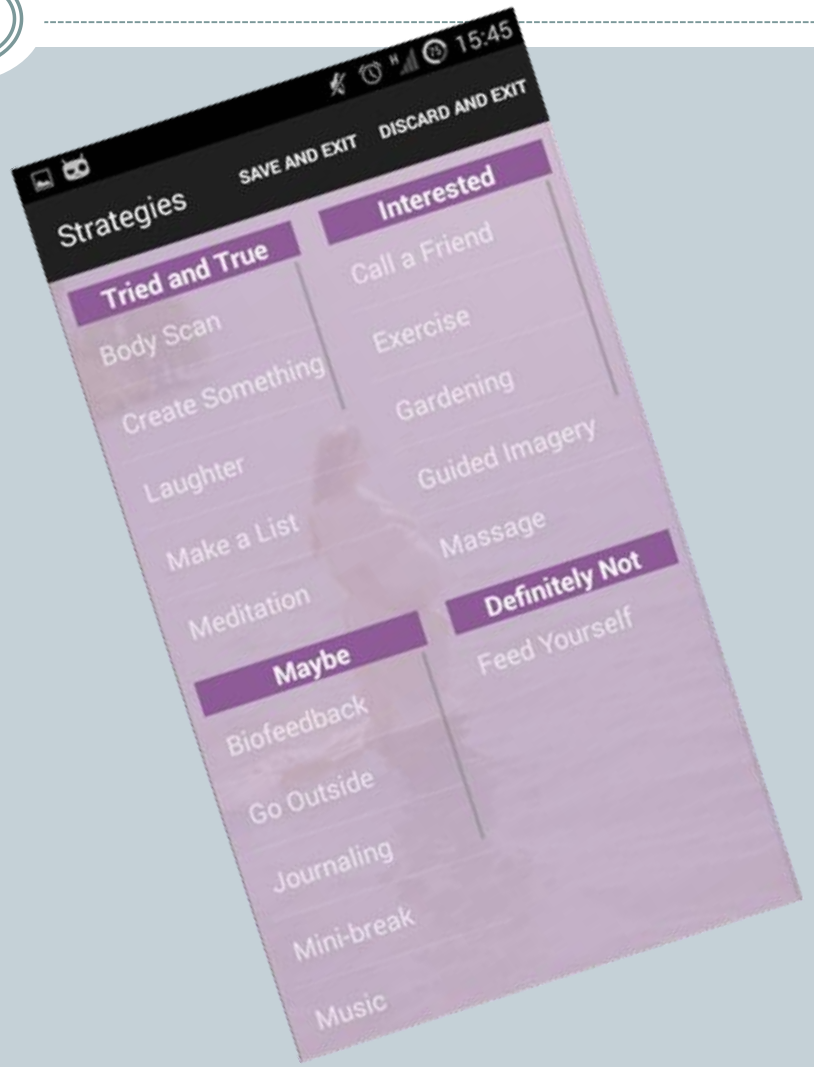
What do you do?

Mild to moderate depression and anxiety

- Practical suggestions e.g. time off work?
- Agencies e.g. Pregnancy Help
- Counselling e.g. Brief intervention counselling, private?
- Community supports?
- Education and support e.g. Mothers Matter , Beyond Blue
- Mindfulness Apps e.g. Mind the Bump , Online courses e.g. Mindful motherhood

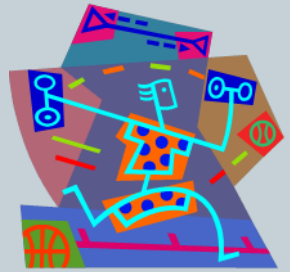
Coming soon…an app to guide the process





More non pharmacological options.....

- with evidence in pregnancy
  - Massage (and training partner in massage)
  - Exercise (aqua exercise)
  - Yoga/Qi exercise
  - Music
  - Guided imagery/relaxation training
  - Cognitive remediation e.g. Elevate



Sarah 6 weeks later……

- Re-presents with her husband. Crying every day for past 3 weeks , has been unable to return to work , constantly anxious and is developing panic attacks. Not sleeping well, and is has started to experience fleeting suicidal thoughts.

- What would you do now?

Assess Risk…

- How strong and intense are suicidal thoughts?
- Has she acted on them before?
- Any protective factors?
- If appropriate refer to Crisis Resolution

Screening Tools

- Depression: Edinburgh Postnatal Depression Scale
- Bonding: Postnatal Bonding Questionnaire
- ‘my baby does not feel like mine’

Prescribing antidepressants in pregnancy

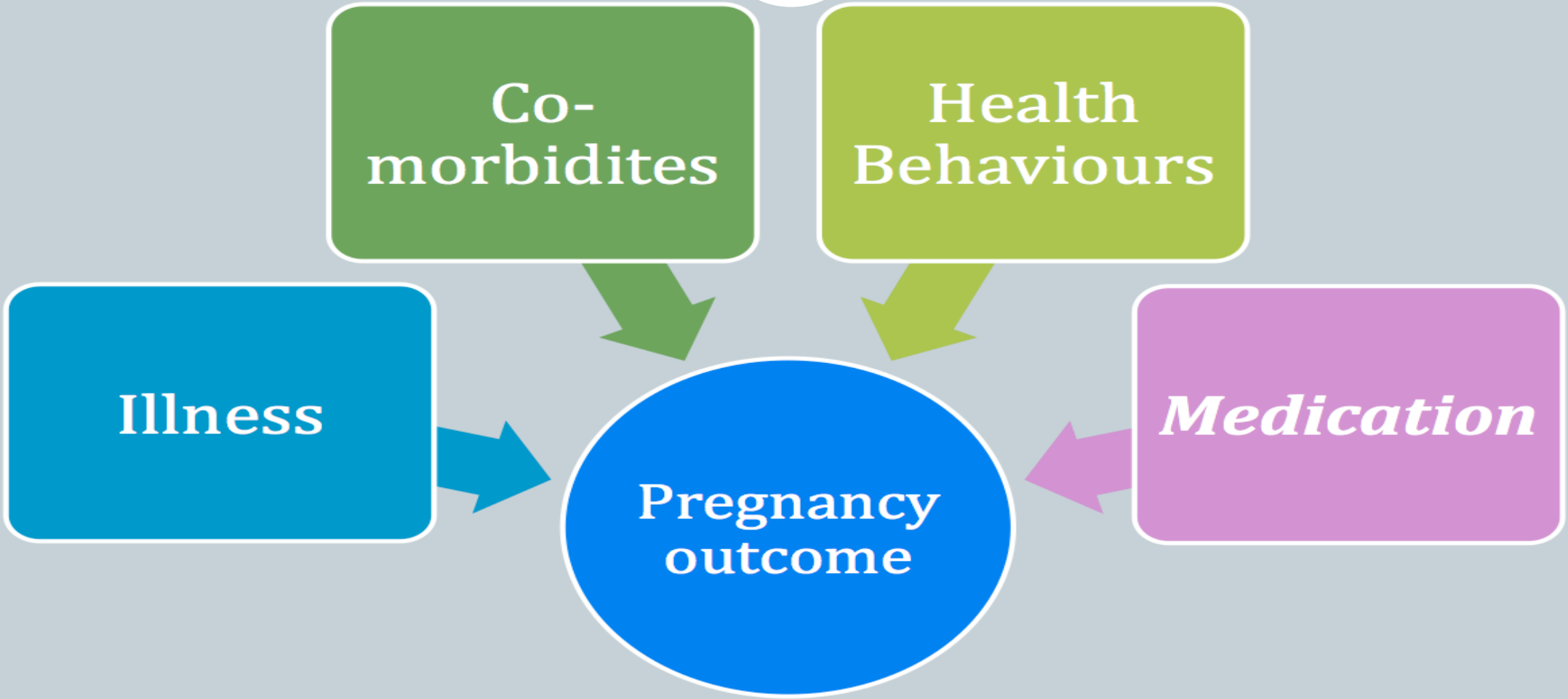
- What is the indication?
- Moderate to severe depression and anxiety

Weighing up the risks

•What are the risks to me & the baby if I take medications?
•Major malformations?
•Obstetric problems?
•Neonatal problems?
•Long term problems?
•Can I breastfeed?

What is the risk to me and the baby if I don't take medications?
•What is the likelihood of relapse?
•What are the consequences of relapse?
•What is the effect of untreated illness on the baby?

Effect of illness on pregnancy outcome



Risks of antidepressants in pregnancy

- Spontaneous abortion??
- Birth defects - cardiac malformations 0.86-2% (c.f.0.8%)
- Neonatal adaptation 10-30%
- Persistent Pulmonary Hypertension
- Pregnancy induced hypertension
- Post Partum Haemorrhage
- Autism
- Overdose (TCAs)

Antidepressant categories for pregnancy and breastfeeding

Medicine	Pregnancy[5]	Breastfeeding[6]
TCAs	C[#]	Compatible[*]
Citalopram	C	Compatible
Escitalopram	C	Compatible[**]
Fluoxetine	C	Compatible[***]
Mirtazapine	C	Compatible
Paroxetine	D[##]	Compatible
Sertraline	B	Compatible
Venlafaxine	C	Compatible

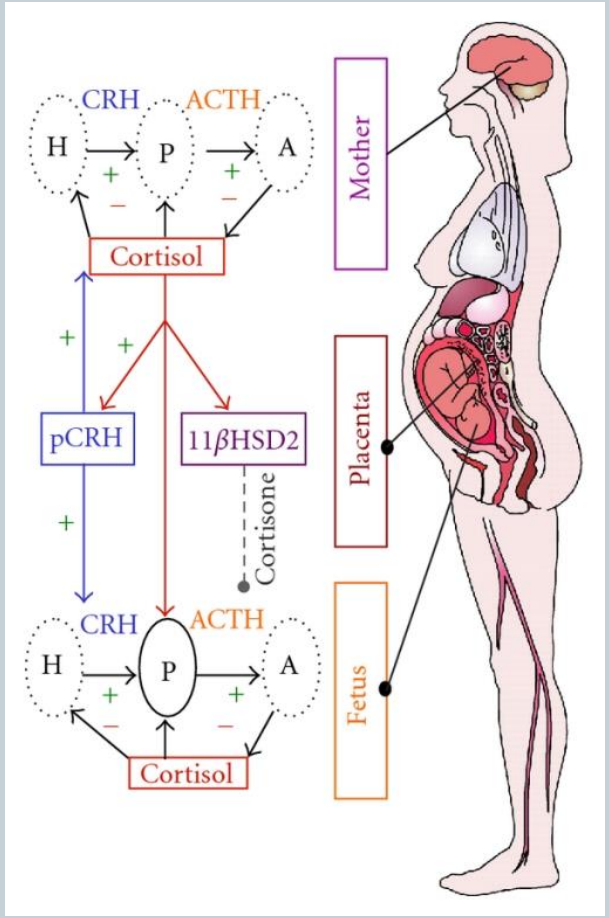
Impact of Depression in the Perinatal Period

- Poor antenatal care
- Obstetric outcomes
- Poor health behaviours
- Relationship with baby
- Health & development of baby
- Other children
- Partner relationship
- Severe – suicide, infanticide, abuse, neglect, long-term emotional, cognitive, behavioural effects

Pregnancy stress and pregnancy outcomes?

- Slightly shorter gestation, smaller head circumference
- Mixed handedness
- Increased childhood anxiety
- Increase in ADHD symptoms

(Glover et al, J.Child Psychology and Psychiatry,2007)



Impact of postpartum depression mother-infant relationship

More of:	Less of:	Outcomes:

• Sad face
• Unresponsiveness
• Internal preoccupation
• Amotivation (neglect)
• Slow to respond
• Tiredness
• Irritability
• Inconsistent/ rejecting/ intrusive/ harsh
	• Availability
	• Affection
	• Confidence
	• Sensitivity
	• Safety
	• Healthy development behaviours:
	  • Talking/Reading/ Singing
	  • Smiling/ playing
		• Sleep problems
		• IQ
		• language development
		• secure attachment
		• ADHD
		• Behavioural problems
		• Emotional/ cognitive problems
		• Psychiatric Illness
		• abuse/ neglect
		• FTT
		• Hospitalisations

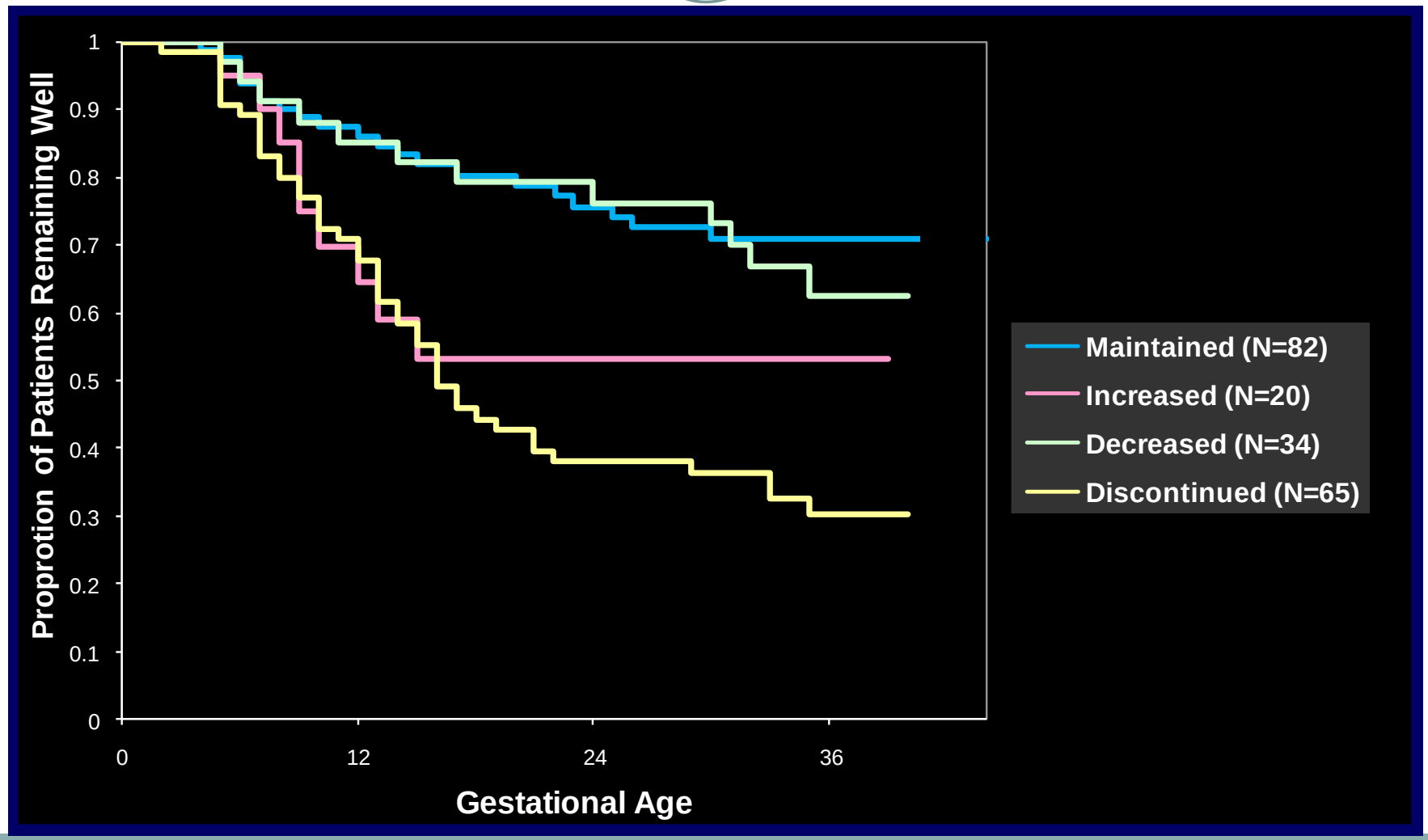
Starting an antidepressant in pregnancy

- Choice of antidepressant - what has worked in past?
- De novo - Sertraline or Escitalopram
- Others:Venlafaxine, Paroxetine relatively higher risk neonatal withdrawal
- Fluoxetine higher amounts in BM and long half life
- TCAs Nortriptyline – effective but not well tolerated
- Avoid MAOIs in pregnancy and breastfeeding

If already on antidepressant…

- Preconception counselling ideally…..
- Don’t stop suddenly! Relapse 68%
- What's the indication? Diagnosis and severity
- Response?
- Have they tried to come off it in past?
- If come off - gradually (1 months)and moniter
- To switch or not to switch…… Eg Fluoxetine - not necessarily
- No longer advise dose reduction around delivery

Depression:
time to relapse in patients who maintain or discontinue antidepressant medication



Cohen et al. *JAMA*. 2006.

Prescribing…

- Case by case basis
- Collaborative decision making
- Full discussion of potential risk and benefits inc written material
- Document discussion took place
- Lowest effective dose
- Avoid polypharmacy
- Consult – websites e.g. mothertobaby.org or ring Mothers and Babies

Prescribing in pregnancy……

Post partum

- Sarah has had a baby boy who is now 10 weeks old
- He is born was born at term - spent 24 hrs in NICU, but now growing well and breast fed
- Sarah reports he is unsettled and thinks he has reflux –maybe he needs some medication ?
- Her baby is calmly alert & responding to you, but Sarah looks anxious, exhausted and on the edge of tears
- She is on sertraline 100mg and has been trying to implement her CBT techniques but feels her son is “too unwell”

Post partum supports

- Plunket - PPNAP in Canterbury and Timaru
- Oranga Whakamomori (CHCH urban)
- Peer support :PND Canterbury (Christchurch based) Mothers supporting mothers (Rangiora/Kaiapoi)
- Practical: Enlisting family, agencies e.g. Bellyful

Referral to MMHS(Or how do you make sure your patient is seen…)

- Advice, assessment or treatment?
- Has a trial of treatment been tried and failed?
- Current Psych History
- Past Psych History
- Family history
- Medications

- A&D
- Social situation
- Supports
- Ethnicity
- Bonding/attachment concerns
- RISK to self/others/baby

Post partum psychosis/ Bipolar disorder

THE GP ROLE IN IDENTIFICATION

Bipolar / Post Partum Psychosis

- 0.1-0.2%
- Can be very predictable !
- At least 30- 50% chance relapse in first 4-6 weeks postpartum if Bipolar 1
- Risk increased if previous postpartum episodes or family history
- Psychiatric emergency as risks very high
- Usually need hospitalised. Preferably in MB unit, will need close monitoring
- Preconception counselling and mental health birth plan required
- Trigger of sleep deprivation

Daksha Emson and Freya

- Presents saying she would like to get pregnant…..what would you do?

TABLE 1 Risk factors for postpartum psychosis

Primiparity
Discontinuation of mood stabilizer
Obstetrical complications
Perinatal infant mortality
Previous bipolar episodes, psychosis, or postpartum psychosis
Family history of postpartum psychosis
Family history of bipolar disorder
Sleep deprivation
Increased environmental stress
Lack of partner support

TABLE 2	Clinical features of postpartum psychosis
Onset	Acute, within 2 weeks postpartum but as early as day 1
Cognitive	Poor concentration, delirium-like impaired sensorium/orientation; rule out organic causes
Behavioral	Agitated, hyperactive, emotional distance or coldness/perplexity
Mood	Elated, labile, dysphoric, or less frequently depressed
Affect	Flat or incongruent
Speech	Rambling
Sleep	Insomnia
Thought content	Mood-incongruent delusions • Thought broadcasting • Ideas of reference • Infant being harmed/killed • Persecutory • Jealousy • Of being controlled Mood-congruent delusion of grandiosity
Thought process	Disorganized, flight of ideas
Perception	Hallucinations • Organic (eg, visual, olfactory, tactile) • Commanding auditory
Suicide/homicide	Suicide (5%) Infanticide (4%)

What can the GP do?

- Identification of high risk women early on – refer preconception counselling
- Women who are at high risk i.e.Bipolar 1 should be referred to MHS even if currently well
- Will need active medication management
- Mental health birth plan and close monitering postpartum
- If become involved in postpartum in acute onset of illness – treat as emergency and refer urgently
- Sleep!!!! - short term sleeping tabs, xpress milk, etc

Bipolar treatments

- Lithium
- Atypical antipsychotics
- Mood stabilisers
- Avoid sodium valproate in women of childbearing age
- Interpersonal Social Rhythm Therapy IPSRT.org

Lithium	Ebsteins anomaly Neonatal tox Breastfeeding	Refer USS & Echo 16/40 Monitor Li, TFTs, U&E Care at delivery
Carbamazepine	⇑ Malformations Cardiac, NTD, cranio-facial, LBW ? neonatal Haemorrhage ? DD	Avoid if poss BF prob safe
Lamotrigine	No ⇑ malformations ?? Oral clefts	OK BF prob safe
Valproate	Malformations > 10% Neonatal probs DD++	**AVOID** Low dose Folic Acid mg

Atypical Antipsychotics

	Not well studied
Olanzapine	No Major Cong. Ab.
Quetiapine	? Maternal wt gain
Risperidone	? Gest Diabetes
	? High birth weight
	? Neonatal hospitalisation
Aripiprazole	
Ziprasidone	
Clozapine	Floppy baby
	? Agranulocytosis

TAKE HOME MESSAGES

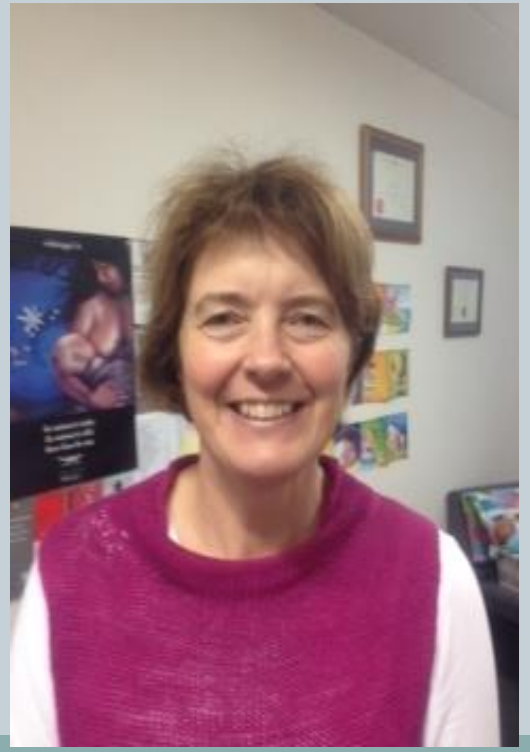
- Preconception counselling for young women prescribed antidepressant medicines
- Discuss non-pharmacological interventions
- Consider antidepressants for moderate to severe depression /ANXIETY
- Be aware THAT all ANTIDEPRESSANTS CARRY some risk during pregnancy – BUT THAT NOT TREATING HAS RISK TOO…..
- Provide information about compatability with breastfeeding
- Refer bipolar 1 women to mhs even if well for monitering around delivery
- Suspected post partum psychosis is a emergency

WHEN TO REFER TO MMHS

- Telephone advice
- Preconception counselling if medications complex and or severe disorder
- Bipolar disorder (even if well)
- Complex moderate and severe MI which has not responded to trial of treatment in community

The doctors you might speak to.....

- Dr Sue Luty
- Dr Katy Brett
- Dr Liz Macdonald



Websites and Apps…

Thank you!