Psychological disorders remain among the most highly stigmatised conditions from which women suffer and psychiatric illness is a major cause of maternal death. This book covers the psychological conditions associated with the many phases of the woman’s lifespan. For each condition, the nature and extent of the condition, detection or diagnosis, the pharmacological and psychosocial interventions available and the importance of referral and co-working with multidisciplinary teams are covered. Substance misuse, mood disorders, severe mental illness, eating disorders, personality problems, suicide and deliberate self-harm are considered, with an emphasis on the growing evidence base for treatment for psychiatric disorders.

The book highlights how a clinician can effectively intervene or refer those women whom they suspect of having a primary or secondary associated mental disorder. It is essential reading for MRCOG candidates and any health professional needing a clear understanding of this important area.
Psychological Disorders in Obstetrics and Gynaecology for the MRCOG and Beyond

Khaled MK Ismail MD MRCOG
Senior Lecturer/Consultant in Obstetrics and Gynaecology, Academic Unit of Obstetrics and Gynaecology, Keele University Medical School, University Hospital of North Staffordshire, Stoke-on-Trent ST4 6QG, UK

Ilana Crome MD FRCPsych
Professor of Addiction Psychiatry, Academic Psychiatry Unit, Keele University Medical School, Harplands Hospital, Stoke-on-Trent ST4 6TH, UK

PM Shaughn O’Brien MD FRCOG
Professor of Obstetrics and Gynaecology, Academic Unit of Obstetrics and Gynaecology, Keele University Medical School, University Hospital of North Staffordshire, Stoke-on-Trent ST4 6QG, UK

Series Editor: Jennifer Higham FRCOG
Contents

Abbreviations vii

Introduction ix

1 Diagnosis and management of psychological problems 1
2 Basic science 13
3 The menarche 22
4 The menstrual cycle 29
5 Psychological aspects of infertility and its management 41
6 Pregnancy and the puerperium 44
7 Eating disorders 56
8 Menopause and perimenopause 64
9 Substance use disorders 70
10 Other disorders 83

Further Reading 89

National organisations and support groups 90

Index 99
Abbreviations

ACTH  adrenocorticotropic hormone
BMI  body mass index
CNS  central nervous system
CRH  corticotrophin-releasing hormone
CTG  cardiotocogram
DSM-IV  *Diagnostic and Statistical Manual of Mental Health* 4th edition
ECG  electrocardiogram
EPDS  Edinburgh Postnatal Depression Scale
ESR  erythrocyte sedimentation rate
FSH  follicle-stimulating hormone
GABA  gamma amino butyric acid
GABA-A  gamma amino butyric acid type A
GnRH  gonadotrophin-releasing hormone
HFEA  Human Fertilisation and Embryology Authority
HPA  hypothalamic-pituitary-adrenal system
HRT  hormone replacement therapy
ICD-10  *International Classification of Diseases*, 10th edition
IQ  intelligence quotient
LH  luteinising hormone
LLPDD  late luteal phase dysphoric disorder
MAO  monoamine oxidase
MAOIs  monoamine oxidase inhibitors
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>NaSSA</td>
<td>noradrenergic and specific serotonergic antidepressant</td>
</tr>
<tr>
<td>NICE</td>
<td>National Institute for Clinical Excellence</td>
</tr>
<tr>
<td>PMDD</td>
<td>premenstrual dysphoric disorder</td>
</tr>
<tr>
<td>PMS</td>
<td>premenstrual syndrome</td>
</tr>
<tr>
<td>PSST</td>
<td>premenstrual symptoms screening tool</td>
</tr>
<tr>
<td>RCTs</td>
<td>randomised controlled trials</td>
</tr>
<tr>
<td>SAD</td>
<td>seasonal affective disorder</td>
</tr>
<tr>
<td>SNRI</td>
<td>serotonin-noradrenaline reuptake inhibitor</td>
</tr>
<tr>
<td>SSRI</td>
<td>selective serotonin reuptake inhibitor</td>
</tr>
<tr>
<td>TACE</td>
<td>tolerance, annoyed, cut down, eye opener</td>
</tr>
<tr>
<td>TRH</td>
<td>thyrotrophin-releasing hormone</td>
</tr>
<tr>
<td>TSH</td>
<td>thyroid-stimulating hormone</td>
</tr>
</tbody>
</table>
Introduction

Psychological disorders remain among the most highly stigmatised conditions in medical practice. Women may suffer, knowingly or unknowingly. Perhaps this is the major reason why the 2000–2002 report of the Confidential Enquiries into Maternal Deaths uncovered the startling finding that, when all deaths up to 1 year after delivery were taken into account, psychiatric illness was not only the leading indirect cause of death but also the leading cause of maternal deaths overall.¹

This outcome can be the result of lack of access to appropriate services, inadequate assessment, recognition and diagnosis, ineffective treatment, inconsistent review and monitoring of the interventions that have been implemented, and poor coordination between services.

This book attempts to redress the balance. It covers the psychological conditions associated with the many phases of the woman’s life span: menarche, menstrual disorders, pregnancy and menopause. In parallel, but linked with cross-referencing, it aims to outline the main psychological comorbid symptoms or syndromes with which women may present.

The highlight is on description of the nature and extent of the particular condition, detection or diagnosis, the pharmacological and psychosocial interventions available and the importance of referral to and co-working with multidisciplinary teams. Substance misuse, mood disorders, severe mental illness, eating disorders, personality problems, suicide and deliberate self-harm are considered.

We highlight the growing evidence base for treatment for psychiatric disorder. It is important to underline the rapid scientific advances in mental health in general and in relation to obstetrics and gynaecology, through an understanding of the neurosciences, linked to psychosocial influences, and to the higher priority given to mental health in the national policy agenda.

For all these reasons we hope to stress how you can intervene effectively by pointing to how you can recognise and treat directly or refer those women whom you suspect have a primary or secondary associated mental disorder.
DEFINITIONS

Psychiatry  A branch of medicine concerned with the study and treatment of mental illness and behavioural disturbance.

Psychiatrist  A medical practitioner specialising in the diagnosis and treatment of mental illness.

Psychology  The scientific study of the human mind and its functions.
             The mental characteristics or attitude of a person.
             Mental factors governing a situation or activity.

Psychotherapy  The treatment of mental disorder by psychological rather than medical means.

Psychosocial  The inter-relationship of social factors and individual thought and behaviour.

Reference

1 Diagnosis and management of psychological problems

Introduction

This chapter outlines the common types of psychological problems, the principles of assessment, pharmacological modalities, psychological interventions and particular problems of special groups of people. Later chapters outline where endocrine and even surgical interventions, in rare situations, may be relevant.

The largest cause of maternal deaths overall is psychiatric illness and, of the 391 women whose deaths were reported to the Confidential Enquiries into Maternal Deaths in the United Kingdom in 2000–2002, 8% were substance misusers (Figure 1.1).1

![Chart showing maternal deaths from psychiatric, accidental, violent, and unascertained causes]

**Figure 1.1** Maternal deaths from psychiatric, accidental, violent, and unascertained causes; England and Wales 2000–02; reproduced with permission from CEMACH1
Health professionals must have a sound knowledge of the adverse consequences of mental illness in order to detect, treat and provide care. Psychological symptoms and psychological syndromes that often go unnoticed can have serious implications for the woman, her family and health practitioners. It is the role of the obstetrician and gynaecologist to be aware of the symptoms of common syndromes, always to consider the possibility of coexisting psychological problems and to make a diagnosis where they are reasonably confident or request support when necessary. In summary, the obstetrician and gynaecologist has a duty to have a high index of suspicion with regard to psychological problems. Similarly, it is important for psychiatrists and other healthcare professionals to be aware of the physiological and psychological processes specifically related to obstetrics and gynaecology.

Psychological problems may pre-date, be associated with or be precipitated by obstetric or gynaecological problems. Women may actually present with a range of different symptoms. However, they may also find it difficult to admit to and access help and support for specific psychological problems, even if they or their families do recognise their problems.

**General principles of assessment**

The ability to carry out an assessment in an empathic, non-judgemental manner is essential for the success of any treatment. Further management should be based on the clinician’s balanced interpretation of consistency between the systematic history, clinical condition and results of investigations. Communication of the assessment to the woman, her family and relevant professionals (with consent) is part of the process. It is important to recognise that there may be a psychological component to the presentation, so it may be important to refer to other medical specialists, such as psychiatrists and their teams, other professions, such as psychologists and social workers, or agencies such as social services.

A high index of suspicion is vital. First and foremost, it is crucial to determine if the woman is already under the care of a physician or psychiatrist or receiving pharmacological treatment or psychological interventions. If so, contact should be made with the appropriate teams with the woman’s agreement. Furthermore, unexplained physical symptoms should alert the obstetrician to the possibility of psychological difficulties and the need to review and monitor perhaps unnecessary investigations. The past psychiatric history of the woman is also relevant. The use of the Mental Health Act should be cautiously probed if you think this might have been an issue at any time. Stressors
such as bereavement, unemployment, promotion, physical and sexual abuse, bullying, harassment, recent marriage, separation or divorce may predispose people to the development of psychological and physical problems.

It is important to try to determine aspects of the family background or social circumstances that may be pertinent: past or current psychiatric illness, including treatment (particularly current drug treatment), admission, response to treatment in a close relative (parents, siblings, children, grandparents, aunts or uncles).

The woman must be treated with respect and courtesy. Ensure that she recognises that you are there to support improvement in her health function. During the consultation give her and her relatives time, so that they can express themselves in their way, listen with understanding, be reassuring, make eye contact and use their names. Try not to use technical language, explain what you mean if you do so, and couch it in a way that does not appear patronising. If the woman is irate, taxing, seductive or inquisitive, try not to take it personally and respond politely, with understanding. At the same time, be firm and clear with regard to the nature of the relationship, which is professional.

If appropriate, an overall assessment of the general level of functioning in educational and occupational domains, relationships with parents, her peers, her partner, children, colleagues and professionals, should be sought.

Would you describe this person’s situation as stable, chaotic, deteriorating, improving, a cause for concern or a contributory factor to their mental or physical state? Is the woman well supported by a network of family, friends and professionals? Is the woman living in suitable accommodation? Is the woman homeless? Is the woman a lone parent, a widow or living alone? Is there concern, anxiety, evidence or suspicion of domestic violence, substance misuse, legal difficulties or criminal activities?

Investigations should be appropriately targeted. Unless these are clearly necessary to clarify a diagnosis, one should be aware there is always the possibility that the woman is being over-investigated.

**Diagnostic categories**

**PSYCHOSIS**

Schizophrenia is the most common psychotic disorder. It is characterised by abnormal perceptions, beliefs, thought processing and volition. There are acute and chronic forms. In the acute type, auditory and bodily (somatic) hallucinations, delusions, thought insertion and withdrawal,
as well as passivity experiences can occur. In the chronic form, negative symptoms: apathy, blunted affect, social withdrawal, self-neglect and poverty of thought and speech, are manifest.

**AFFECCIVE SYMPTOMS**

There are two kinds of mood disorder: mania and depression.

*Mania*

This state can develop rapidly; that is, over days, and results in elation, grandiosity, overactivity, disinhibition and exhaustion as well as lability of mood. Psychotic symptoms accompany mania.

*Depression*

Depression is characterised by physical and psychological symptoms. The psychological problems include low mood, lability of mood, irritability, self-blame and guilt, feelings of hopelessness and helplessness and loss of interest. The physical difficulties include fatigue, lack of energy, poor sleep, poor appetite, weight loss, agitation or retardation, loss of libido and dehydration. In addition, women may suffer from inability to concentrate and complain of memory loss.

Sometimes depression is associated with psychotic symptoms such as delusions or hallucinations. The most serious risk is that of suicide.

**SUICIDE AND DELIBERATE SELF-HARM**

Deliberate self-harm refers to harm that does not result in death but is a way of coping with distressing feelings. This may occur in a state of crisis, stress or worsening mental state and psychiatric symptoms. Women attempt suicide more often than men but men complete suicide more often than women (Figure 1.2). Suicide rates for men, which were rising through the 1970s and 1980s, have decreased steadily since 1998. The rate for 2003, 18.1 deaths/100,000 population, was the lowest since 1978. Suicide rates for women, which fell steadily in the 1980s and early 1990s, have decreased only slightly since the mid-1990s. The rate for women remained around 5.8 deaths/100,000 population in each of the years 2001 to 2003.

Single, divorced or widowed people are more likely to attempt suicide than those who are married. Stressful life events such as job loss, bereavement and financial difficulties are associated with suicide. Caring for a child is protective. Unsuccessful attempts in the past make it more likely that a future attempt will be successful. Substance misuse
is a powerful predictor of deliberate self-harm and suicide. An overdose may not be accidental and the assessment should always explore underlying suicidal intent or maladaptive coping responses.

Depression, bipolar disorder, personality disorder and psychotic illness may be associated with deliberate self-harm and with eventual suicide.

**ANXIETY**

Anxiety presents as recurrent, inappropriate, unrealistic, intrusive and irrational fear. There are several sorts of anxiety disorder; that is, panic, agoraphobia, social phobia, generalised anxiety disorder, obsessive-compulsive disorder and post-traumatic stress disorder.

**POST-TRAUMATIC STRESS DISORDER**

Women may have experienced such severe levels of abuse – physical, sexual or psychological – or other stressful experiences, that they develop a diagnosable condition.

Importantly for the purpose of this book, people may present with specific fears relating to their health; that is, unexplained somatic complaints or hypochondriacal disorder. Of course, anxiety itself may be
accompanied by many somatic symptoms, which may mimic physical disorders. These include sweating, dry mouth, palpitations, tremor, hyperventilation, headache, backache, flushing, nausea, diarrhoea, urinary frequency and muscular tension.

PERSONALITY DISORDERS

Personality disorders are primary disorders. The features are recognisable by adolescence and persist. They are defined as maladaptive patterns of behaviour that cause distress and difficulties in social functioning which impact on the individual and others. There are several kinds of personality disorder; for example, paranoid, schizoid, dissocial, emotionally unstable, histrionic, obsessional, anxious and dependent.

ACUTE ORGANIC BRAIN REACTION (DELIRIUM OR CONFUSIONAL STATE)

This is characterised by:
- impaired consciousness
- poor attention; that is, disorientation for time, place or person
- illusions, hallucinations, delusions
- overactivity, restlessness, agitation
- emotional lability
- drowsiness and insomnia
- perplexity
- suspiciousness.

DIETING DISORDERS

Dieting disorders include anorexia nervosa and bulimia nervosa. Both are associated with serious psychiatric and physical disturbances. In both, individuals adopt restricted eating patterns and excessive dieting disorders. Sufferers over-evaluate their shape and weight as a marker of self-worth.

In anorexia nervosa there is an unduly low body weight, while in bulimia nervosa there is recurrent bingeing, vomiting and laxative use.

Anorexia nervosa may result in amenorrhoea, dry skin, fine downy hair, fatigue, abdominal discomfort, headaches, stunted growth, hypothermia, hypotension, brachycardia and arrhythmias, hyperactivity.
brittle bones and osteoporosis. Dental decay, polyuria, paresthesia, stress fractures and swollen salivary glands occur because of the behavioural problems.

In bulimia, a range of problems result: amenorrhoea, dental decay, irritable bowel, nausea, fatigue, headaches, insomnia, hair loss, callused knuckles, urinary tract infections, bruising and swollen hands, feet and salivary glands.

As will be apparent, these symptoms overlap with those of depression, personality disorders, obsessional symptoms, and gastrointestinal disorders.

**General principles of treatment**

**PSYCHIATRIC DISORDERS AND DRUG TREATMENT**

*‘Older’ antipsychotics*

Antipsychotic medication (neuroleptics or major tranquillisers) is the main form of medication. These drugs reduce relapse, the most common reason for which is non-compliance. ‘Classical’ antipsychotics, such as chlorpromazine, thioridazine, sulpiride, act on ‘positive’ symptoms. There are depot injections available. They are used for schizophrenia, mania and organic brain syndromes.

*Atypical antipsychotics*

These act on both the ‘positive’ acute symptoms and ‘negative’ symptoms. Examples of these drugs are clozapine, risperidone, olanzapine, quetiapine and amisulpiride. These drugs do not have the anticholinergic and extrapyramidal adverse effects of the older drugs. However, some, such as weight gain, seizures, sedation, dizziness and agranulocytosis, are common to both.

*Antidepressant medication*

There is a large range of antidepressant medication available. These include:

- tricyclic, e.g. amitriptyline, clomipramine, dosulepin (dothiepin), doxepin, imipramine, lofepramine, nortriptyline, trimipramine
- tetracyclic, e.g. mianserin, maprotiline, amoxapine
- selective serotonin reuptake inhibitors (SSRIs), e.g. citalopram, sertraline, fluoxetine, fluvoxamine, paroxetine
• monoamine oxidase inhibitors (MAOIs), e.g. isocarboxazid, phenelzine, tranylcypromine, moclobemide
• serotonin-noradrenaline reuptake inhibitors (SNRIs), e.g. venlafaxine
• post-synaptic serotonin receptor blockers and reuptake inhibitors, e.g. trazodone
• noradrenergic/specific serotonergic antidepressants (NaSSA), e.g. mirtazapine.

These are variously used for depression, panic disorder, obsessive–compulsive disorder and bulimia nervosa.

Lithium, sodium valproate and carbamazepine are also used for the prophylaxis and treatment of mania and depression, alone or in combination.

Benzodiazepines

Benzodiazepines are used as hypnotics, sedatives or anxiolytics. There are many types, with different half-lives. It is important to recognise that they can produce a withdrawal syndrome, i.e. dependence, even if low doses have been prescribed (or misused). If taken in combination with other drugs and alcohol, overdose can result. There are alternatives, such as buspirone, zolpidem and zopiclone, which can be used and do not appear to lead to dependence.

DRUG USE IN PREGNANCY AND BREASTFEEDING

These are covered in Chapter 6.

PSYCHOLOGICAL INTERVENTIONS

A wide range of effective interventions is available. These interventions may be brief or intensive and delivered in community, primary care, outpatient or inpatient settings, by specialist psychiatrists and mental health teams, and by general practitioners and their teams. They may be for an individual, in a group setting or for a family (Box 1.1).

Brief, minimal and short-term interventions, including ‘counselling’ and ‘motivational interviewing’ have become popular and the latter is developing a growing evidence base.
**BOX 1.1 COMMONLY USED PSYCHOLOGICAL INTERVENTIONS:**

- Non-directive counselling
- Cognitive behavioural approach
- Social network behaviour therapy
- Family therapy
- Motivational interviewing

**Psychological approaches**

**BOX 1.2. IMPORTANT COMMON OBJECTIVES OF PSYCHOLOGICAL TREATMENTS**

<table>
<thead>
<tr>
<th>Approach</th>
<th>Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Problem solving</strong></td>
<td>Developing competence in dealing with a specific problem</td>
</tr>
<tr>
<td><strong>Acquisition of social skills</strong></td>
<td>Mastery of social and interpersonal skills by assertiveness or anger control</td>
</tr>
<tr>
<td><strong>Cognitive change</strong></td>
<td>Modification of irrational beliefs and maladaptive patterns of thought</td>
</tr>
<tr>
<td><strong>Behaviour change</strong></td>
<td>Modification of maladaptive behaviour</td>
</tr>
<tr>
<td><strong>Systemic change</strong></td>
<td>Introducing change into family systems</td>
</tr>
</tbody>
</table>

**INFORMATION-BASED METHODS**

It should be borne in mind that there is considerable evidence from other health and social care fields that health education and the provision of information, in itself, may be of help, especially in less complex situations. Information needs to be accurate and up to date and should provide positive advice.

**COUNSELLING**

‘Counselling’ is a widely used term, which can be imprecise and which can embody different theoretical models, such as psychodynamic, cognitive or behavioural. In practice, however, counselling may have one or
more objectives: problem solving, acquisition of social skills, cognitive change, behavioural or systemic change. The term may be used to describe therapies that are supportive, directive or motivational, for individuals, groups or families. The term may encompass assessment, engagement and support, together with the development of therapeutic relationships. Box 1.2 shows important common objectives.

**NONDIRECTIVE COUNSELLING**

In nondirective counselling, the person being counselled determines the content and direction of the counselling and explores conflict and emotions at the time. While allowing empathic reflection, the counsellor does not offer advice and feedback.

**COGNITIVE BEHAVIOURAL APPROACH**

The cognitive behavioural approach assumes that the person would like to change and analyses situations that cause the psychological problem, so that these can be altered. Problem solving techniques, self-monitoring, anger management, relapse prevention, assertiveness training and the acquisition of social skills and modification of irrational beliefs or patterns of thought or behaviour are used. For instance, individual, group and family therapies used in the treatment of psychological symptoms and psychiatric disorders are often based on cognitive behavioural approaches.

**SOCIAL NETWORK BEHAVIOUR THERAPY**

Social network behaviour therapy considers the social environment as being important in the development, maintenance and resolution of problems. It maximises positive social support, which is central to the process. The therapist offers advice and feedback and thereby facilitates change in the person’s social world. Behaviour is not interpreted and engagement with significant others is key in bringing about change and achieving goals.

**FAMILY THERAPY**

Family therapy involves attempts to understand and interpret the family dynamics in order to change the psychopathology. Psychological problems are perceived as a symptom of family dysfunction and so altering the dynamics brings about change. Family members are viewed as contributory to the problems. Behavioural techniques may be used in family therapy as well as psychodynamic techniques.
MOTIVATIONAL INTERVIEWING

Motivational interviewing aims to build motivation for change. The focus is on a nonjudgemental approach and the person’s concerns and choices: it elicits strategies from the individual. Motivational enhancement directs the person to motivation for change by offering empathic feedback, advice and information and selectively reinforces certain discrepancies that emerge between current behaviour and goals, in order to enhance motivation for change. Significant others play some part in the treatment but do not have a central role. It is, by and large, a personal therapeutic situation where the individual’s motivation is seen as vital. It aims to alter the decisional balance so that patients themselves direct the process of change.

Delivery of services: monitoring, review and coordination

Collaborative working with other professionals, based on a broadly based multicomponent approach is essential. Services should be designed so that leadership and management are brought together, with an awareness of the views of users and carers, the clinical realities and the evidence to date. It is vital that it is recognised that there are high levels of comorbidity of substance misuse, psychiatric disorder and many other health, educational and social problems for young women. Thus, multidisciplinary and multi-agency services need to be responsive to the real needs of the patient groups by providing the ‘right’ organisational culture and therapeutic environment. There is a need to provide comprehensive and accessible services for parents and children by involving mental health services with children’s services at an early stage in the treatment plan.

Evidence suggests that support with housing, other health and social needs and family involvement produces a better outcome, so that inter-agency collaboration is not just of academic importance.

BREAKING THE CYCLE

Just as pregnant women, mothers and older women may be affected by their history of previous psychosocial experiences and physical health problems, the next generation may be at potential risk, arising out of the consequences of maternal or familial ill-health. Hence, the detection and management of psychological problems is an opportunity that should not be missed.
KEY POINTS

- At present, there is a rapidly accumulating evidence base in the understanding and treatment of psychological disorder.

- Treatment should follow a comprehensive assessment and be part of an overall management plan adapted to the intensity and complexity of the presenting problems.

- Emphasis must be placed on engagement and retention in services, noting that the interventions provided interact with the familial, cultural and environmental background of the woman.

- While it may not be appropriate for the obstetrician and gynaecologist to initiate treatment, women will arrive already on medication. It is necessary to assess whether there may be contraindications related to the obstetric or gynaecological condition, pregnancy in particular. Thus, there is the need to be aware of the type and range of medications available and those which are most commonly used, as well as the adverse effects and especially those in pregnant and nursing mothers.

- There are some groups of women who are at particular risk of neglect from services. Examples are very young women, older women, the socially disadvantaged, the homeless, those with a history of offending behaviour, substance misusers and those from ethnic minorities. These women may experience a great deal of difficulty in seeking support, being offered sustained help, keeping in contact with services and compliance with treatment. Since their needs are often multiple, these groups usually need additional support in the coordination and monitoring of provision. Often they feel less stigmatised by ‘medical’ services for physical problems. Thus, this should be used as the chance to ascertain the need for other services which may be as important, or more important, than the reason for which the woman has consulted you.

Reference