Review Postnatal affective disorders. Part 2: prevention and management

Author Margaret Oates

Key content:
• Women with a history of mental illness should be screened during early pregnancy, as the risk of recurrence following delivery is substantial.
• The risk of suicide in seriously mentally ill women is elevated following childbirth.
• Postpartum psychiatric illnesses respond to the same treatments as at other times; breastfeeding, however, limits medication choice.
• Mothers requiring admission to a psychiatric hospital following delivery should be admitted to a mother and baby unit unless contraindicated.

Learning objectives:
• To recognise the risk factors and preventative measures for postnatal affective disorders.
• To discuss the psychological, pharmacological and social management.
• To understand the potential adverse effects of pharmacological treatment on the developing infant via breast milk.

Ethical issues:
• Do the risks to both mother and infant of not treating postpartum psychiatric illness outweigh the risk to the infant of psychotropic medication?

Keywords: bipolar illness / postnatal depression / psychotropic medication / puerperal psychosis
Introduction
In the first part of this article, we looked at the normal emotional changes in the puerperium and the risk factors, clinical features and prognosis of postnatal affective (mood) disorders. In part 2, we look at the prevention and management of these disorders.

Screening
National Screening Committee policy and the National Institute for Health and Clinical Excellence (NICE) guidelines on antenatal and postnatal mental health do not recommend routine screening in the antenatal period for those at risk of mild–moderate postnatal depression. They also found that there is a lack of evidence to support antenatal interventions to reduce the risk of nonpsychotic postnatal illness. In contrast, the NICE guidelines, the National Service Framework for Children, Young People and Maternity Services and the last three reports of the Confidential Enquiries into Maternal Deaths in the United Kingdom recommend that women are screened at early pregnancy assessment for a previous or family history of serious mental, particularly bipolar, illness, because they face at least a 50% risk of recurrence of that condition following delivery. Those who undertake early pregnancy assessment may need training to refresh their knowledge of psychiatric disorders.

There is little point in screening for women at high risk of developing severe postnatal illness if systems for active peripartum management are not in place and appropriate resources are not available. It is recommended that all women at high risk of developing a severe postpartum illness by virtue of a previous history are seen by a specialist psychiatric team during their pregnancy. A written management plan should be placed in the maternity record in late pregnancy and shared with the woman and her partner, general practitioner, midwife, obstetrician and psychiatrist.

Prevention
If the woman has a previous history of bipolar illness or puerperal psychosis (a variant of bipolar illness), consideration should be given to starting medication on the day after delivery. For bipolar illness, the use of lithium carbonate is thought to reduce the risk of recurrence. The use of antipsychotic medication may also reduce the risk of a postpartum recurrence. Lithium is not, however, compatible with breastfeeding. Some women will not wish to take medication if they perceive that there is a 50% chance of remaining well; they may also place a priority on continuing to breastfeed. On the available evidence, the best protection for a woman with a previous history of bipolar illness or affective psychosis, either following childbirth or at other times, would be to take lithium carbonate from day one, achieving a therapeutic level as soon as possible.

Women with a previous history of very early onset puerperal psychosis in the first week following childbirth may be at risk before an effective serum lithium level is achieved. For these women, the addition of an antipsychotic should offer added protection in the early days. Breastfeeding mothers at risk of developing a bipolar or mixed affective illness can take an anticonvulsant mood stabiliser, carbamazepine or sodium valproate, as an alternative to lithium. The same problem arises, however, with the time taken to achieve a satisfactory serum level. There is a lack of evidence to show that antidepressants taken prophylactically will prevent the onset of a depressive psychosis. Antidepressants should be used with great caution in any woman who has bipolar disorder in her personal or family history because of the propensity of antidepressants to trigger manic illness.

The most important aspect of preventative management—one that will promote early identification and the avoidance of a life-threatening emergency—is close surveillance and contact in the early weeks, which is the period of maximum risk. A specialist community perinatal psychiatric nurse, together with the midwife, should visit on a daily basis for the first 2 weeks and remain in close contact for the first 6 weeks. The local mother and baby unit should be notified of the woman’s estimated date of delivery and systems put in place for direct admission if necessary. The acute onset and rapid escalation of symptom severity in puerperal psychosis usually necessitates early admission to avoid unnecessary delay in treatment or a crisis situation.

The Confidential Enquiries into Maternal Deaths: psychiatric causes
The 2000–2002 report from the Confidential Enquiry into Maternal Deaths, Why Mothers Die, and the previous report found that suicide was the second leading cause of indirect death. When additional cases found by Office of National Statistics linkage were taken into consideration, suicide was the leading cause of maternal death overall. In the report from the 2003–2005 enquiry, Saving Mothers’ Lives, suicide was the third leading cause of indirect death and the second leading cause of maternal death overall, including late indirect deaths. The position of suicide in the enquiry was accounted for by a significant fall in the numbers of suicides as well as a rise in the numbers of deaths from cardiac causes. It remains to be seen whether the reduction in the numbers of maternal suicides is a
continuing trend. If so, it may be related to the recommendations of previous enquiries that women should be screened at the booking clinic for a previous history of serious mental illness and proactive plans put in place for the management of that risk.

Despite the fall in the numbers of suicides, the profile of women committing suicide in the first months following delivery remains constant. The majority had a previous history of serious mental illness; this risk was neither identified nor managed during pregnancy. They remained well during pregnancy but suffered from severe postpartum illness, the early stages of which were not recognised. As with previous enquiries, these women were not managed by specialist perinatal psychiatric services or admitted to mother and baby units but were cared for by general adult services.

The majority of women committing suicide postpartum continue to die violently by jumping from a height or hanging. This is in contrast to the commonest method of suicide amongst women in general (self-poisoning) and underlines the seriousness of the illness. Half had a previous history of admission to a psychiatric hospital.

Women also died from other consequences of psychiatric disorders. Some of these deaths were caused by accidental overdoses of illicit drugs. Deaths also occurred from medical conditions that would not have occurred in the absence of a psychiatric disorder. These included the physical consequences of alcohol or illicit drug misuse. A worrying number of deaths, some of which took place in psychiatric units, were due to physical illness missed because of the psychiatric disorder or mistakenly attributed to a psychiatric disorder. These findings underline the importance of remembering that physical illness can present as, or complicate, psychiatric disorders. Suicide is not the only risk associated with perinatal psychiatric disorders.

These findings have major implications for psychiatric and obstetric practice. If psychiatrists were to discuss plans for parenthood with their patients prior to conception; obstetricians and midwives were to detect those at risk of serious mental illness; psychiatric and maternity professionals were to communicate freely with each other and work together; specialist perinatal mental health services were to be available for those women who needed them and all had a greater understanding of perinatal mental illness, not only would a substantial number of maternal deaths be avoided but the care and outcome of other mentally ill women would be greatly improved.

Treatment

There are three components of the management of perinatal psychiatric disorders: psychological treatments and social interventions; pharmacological treatments; and skills, resources and services.

Those who are seriously mentally ill will require all three. Those with the mildest illnesses may require only psychological and social interventions, which can be carried out in primary care.

Psychological

All women with illnesses of all severities and, indeed, those who are not ill but who are experiencing commonplace episodes of distress and adjustment, need good psychological care. This can only be based upon an understanding of the normal emotional and cognitive changes and common concerns of pregnancy and the puerperium. It also requires a familiarity with the clinical features of postpartum illnesses. All of these are discussed in Part 1 of this article.

For most women with mild depressive illness or emotional distress and difficulty adjusting, extra time given by the health visitor—the ‘listening visit’—will be effective. For others, particularly those with more persistent states associated with high levels of anxiety, brief cognitive behavioural therapy and brief interpersonal psychotherapy are as effective as antidepressants and may confer additional benefits in terms of improving mother–infant relationships and satisfaction.² Similar claims have been made for infant massage and other therapies that focus the mother’s attention on enjoying her infant.

Social support

Lack of social support, particularly when combined with adversity and life events, has long been implicated in the aetiology of nonpsychotic depressive illness in young women. Social support not only involves practical assistance and advice but also emotional confidantes, female friends and people who improve self-esteem. There is evidence that organisations underpinned by social support theory, such as Home-Start and Newpin, can have a beneficial effect on maternal and infant wellbeing and, perhaps, on mild postnatal depression.

Pharmacological

In general, psychiatric illness occurring during the postpartum period responds to the same treatments as at other times and there are no specific treatments. Moderate–severe depressive illness responds to antidepressants and psychotic illness to antipsychotics, while mood stabilisers may be needed for those with bipolar illness. The possibility of adverse consequences for the developing infant from breastfeeding, however, makes the choice and dosage of drugs important.
General principles of administering psychotropic medication during pregnancy

- The absence of evidence of harm does not equate to evidence of safety.
- It can take 20–30 years after the introduction of a drug for its adverse consequences to be fully realised, e.g. sodium valproate.
- In general, there is more evidence on older drugs, although this does not necessarily mean they are safer.
- All psychotropic medication passes into the breast milk.
- Both the architecture and function of the fetal central nervous system continue to develop in early infancy.
- Infants are no less likely to suffer from the side-effects of psychotropic medication than adults. Infant elimination of psychotropic medication, however, may be less efficient than adults and their central nervous system may be more sensitive to the effects of these drugs.
- Adverse consequences of medication on the infant are dosage related. If medication is used, it should be used in the lowest effective dose and given in divided doses throughout the day.
- The exposure of the infant to psychotropic medication in breast milk will depend on the volume of milk, the frequency of feeding, weight and age. A fully breastfed infant—6 weeks old will receive relatively more psychotropic medication than an older baby who is partially weaned.
- The threshold for prescribing medication in breastfeeding should be high. If there is an alternative, nonpharmacological treatment of equal efficacy, that should be the treatment of choice.
- Serious mental illness requires robust treatment. In all cases of illness occurring in breastfeeding mothers, the clinician must be able to balance the risk to both mother and infant of not treating the mother against the risk to the infant of treating the mother. The more serious the illness, the more likely it is that the risks of not treating outweigh the risks of treating.

The evidence base for the safety and adverse consequences of psychotropic medication is constantly changing, both in terms of increasing concern and providing reassurance. Any text detailing specific advice is in danger of being quickly out of date and the reader is directed to systematic reviews and meta-analyses published by independent professional organisations or the regularly updated information published by the National Poisons Information Service (see Websites).

No matter what the changing evidence, some general principles apply (see Box 1).

Antidepressants

Tricyclic antidepressants (for example, imipramine, lofepramine, amitriptyline and dosulepin) have been in use for 40 years. There is no evidence of harmful effects in breastfeeding and excretion in breast milk is very low. Doxepin should not be used, however, because it has been reported to cause sedation in infants. Any adverse effects in the fully-breastfed newborn infant can be minimised by dividing the dose; for example, imipramine can be given in three 50 mg doses daily.

Selectiv serotonin re-uptake inhibitors (SSRIs) (for example, fluoxetine, paroxetine and citalopram) have been in use for approximately 15 years and are now the antidepressants most used in the treatment of depressive illness outside pregnancy. The excretion of SSRIs in breast milk is higher than that of tricyclic antidepressants. The fully breastfed newborn may be vulnerable to serotonergic side-effects (jitteriness, poor feeding and sleeplessness). Those SSRIs with a long half-life (fluoxetine and citalopram) should be avoided in the newborn. Venlafaxine and paroxetine are not recommended for use in breastfeeding mothers. In older and heavier infants, particularly those who are partially weaned, other SSRIs, including sertraline, may be less problematic.

Tricyclic antidepressants should be the antidepressant of choice in breastfeeding.

Antipsychotics

There are two groups of antipsychotic medications: the older, ‘typical’ antipsychotics (for example, trifluoperazine, haloperidol and chlorpromazine) and the newer, ‘atypical’ antipsychotics (for example, risperidone, olanzapine and clozapine).

The typical antipsychotics have been in use for 40 years. They pass into breast milk, although the amount to which the infant is exposed is likely to be very small. The added benefits of breastfeeding to the infant probably justify the continuation of breastfeeding, provided that the dose of antipsychotic required is small and divided. Drugs such as procyclidine, which are given to prevent extrapyramidal side-effects, are not recommended.

The manufacturers advise against breastfeeding while receiving atypical antipsychotics but this reflects lack of data rather than evidence of harm. Mothers receiving clozapine should not breastfeed because of the risk of blood dyscrasia in the infant.

Mood stabilisers

Lithium carbonate is a well-established treatment for mania and a prophylactic mood stabilising agent for those with bipolar disorder. Lithium should not be used in breastfeeding, as it is present in substantial quantities in breast milk and can result in infant lithium toxicity, hypothyroidism and ‘floppy baby’ syndrome.

Anticonvulsants have been used as mood stabilisers for 30 years. Carbamazepine was first used in this way and sodium valproate is increasingly the mood stabiliser of choice but, recently, newer anticonvulsants such as lamotrigine and topiramate have started to be used. The advantages of breastfeeding probably outweigh the risks of taking carbamazepine or sodium valproate but the infant should be monitored for excessive drowsiness and, in the case of sodium valproate, rashes. Lamotrigine should be used with caution in breastfeeding because of the increased risk of severe skin reactions in the infant. There is insufficient data on the safety of topiramate.
Hormonal

Progesterone
Previously, natural or synthetic progestogens were widely used to prevent and treat postnatal depression. There is no evidence to support their use in this way: indeed, some evidence suggests they may be depressogenic. 8

Estrogen
Estrogens affect dopaminergic and serotonergic receptors and have been implicated in the aetiology of both puerperal psychosis and postnatal depression. Their use has not been shown to prevent or treat psychiatric conditions in clinical trials. They do, however, have an antidepressant effect. They should not be used as a first-line treatment for postnatal depression because of other problems associated with their use. 8

Service provision
There are a number of national recommendations for the needs of women with perinatal psychiatric disorders. 3–7 The distinctive clinical features of these serious conditions, their physical needs and the necessary professional liaison with maternity services all require specialist skills, knowledge and resources.

Mothers who require admission to a psychiatric hospital in the early months following delivery should, unless it is positively contraindicated, be admitted to mother and baby units. This is not only humane but in the best interests of the infant and cost-effective, as it shortens inpatient stay and prevents re-admission. Specialist perinatal community outreach services should be available to every maternity service, so that the more serious psychiatric problems that arise after delivery can be dealt with, women in pregnancy at high risk of developing a postnatal illness can be seen and professionals in primary care advised. These perinatal psychiatric services should be commissioned by the regional specialised commissioning group.

The majority of women suffering from less serious postnatal mental illnesses do not require specialist psychiatric services. There is a need, however, for integrated care pathways to ensure that women are effectively identified and managed in primary care and, if necessary, referred to specialised services. There is a need to enhance the skills and competencies of health visitors, midwives, obstetricians and general practitioners so that they can themselves deal with the less severe illnesses.

The NICE guidelines for antenatal and postnatal mental health 10 recommend that perinatal mental health services should be organised into managed clinical networks.

Websites
National Poisons Information Service [http://toxbase.u5e.com/].

References

© 2008 Royal College of Obstetricians and Gynaecologists