MATERNAL MENTAL HEALTH

PROF DANA NIEHAUS
DR BELINDA BRUWER
DR ELSA DU TOIT
DR BAVI VYTHILINGUM

Overview

- Introduction to maternal mental health
- Introduction to common psychiatric disorders
  - Anxiety disorders
  - Mood disorders
    - Major depressive disorder, Bipolar disorder
  - Psychotic disorders
  - Substance use disorders
- Management of Psychiatric disorders before, during and after pregnancy
- Mother-baby Attachment
- Conclusion

Introduction: Why should we be concerned?

Maternal and Fetal Mortality

- WHO estimated that women in sub-Saharan Africa have a one in 16 lifetime risk of dying during pregnancy and childbirth, compared with one in 2800 in developed regions
- Maternal mental illness was reported as a leading cause of indirect maternal death in the perinatal period

Austin 2007, Campagne

Focus on Maternal Mental Health

- 15% of females depressed during pregnancy
- 30% symptoms for 1st year of child's life
- 50% symptoms up to child's 5th birthday
- Increased risk for repetitive episodes throughout life
- 70% of pregnant females choose to stop treatment
- 75% relapse
- Pre-natal stress, such as maternal depression, associated with adverse neurodevelopmental outcomes for children such as cognitive, behavioural, physical and emotional problems

Antenatal Care

- SASH: 15,9% of people received treatment
- Lower treatment rates in pregnant women
- Depressed woman less likely to seek and less likely to receive treatment
- Developing countries focus on physical needs

Sawyer 2010

Maternal and Fetal Mortality

- Suicide
  - leading cause of indirect maternal deaths
  - 73% pre-existing mental illness
  - 50% in contact with psychiatric services
- Filicide
  - 72% pre-existing mental illness
  - 49% depressed
  - 38% during perinatal period

Yates 2012, Friedman, Austin 2007

Morbidity

- Psychiatric disorders during pregnancy are associated with
  - poor obstetric outcomes
    - Poor obstetric outcomes:
    - Increase antepartum bleeding
    - Increase gestational hypertension
    - Pre-eclampsia
    - Increased caesarean delivery
    - Preterm delivery
  - poor antenatal care
  - substance abuse
  - high risk of postpartum psychiatric illness
  - adverse infant and family outcomes

Obstetric Outcomes

- Poor physical health
  - Reciprocal relationship
  - Pre-eclampsia
- Miscarriage and stillbirth
- Prematurity
- LBW
- Operative delivery
- Admission to neonatal ICU

Campion 2012, Gold 2007

Substance Use

- Depressed females much more likely to abuse substances (alcohol, nicotine)
- Direct toxic effects: substantial adverse impact on pregnancy (IUGR, Prematurity, SIDS) and baby (FAS)
- ETOH
  - 1/4 preconception
  - 71% stopped when pregnancy recognition (often well into 1st trimester)
  - MDD associated with ETOH use
  - Increase smoking, STD, intimate partner violence
  - FAS
- Nicotine
  - largest preventable cause of death (UK)
  - mentally ill more likely to smoke
  - LBW, Prematurity, SIDS, ADHD

Chang 2008, May 2009, Mary J. O'Connor 2011

Postpartum Effect

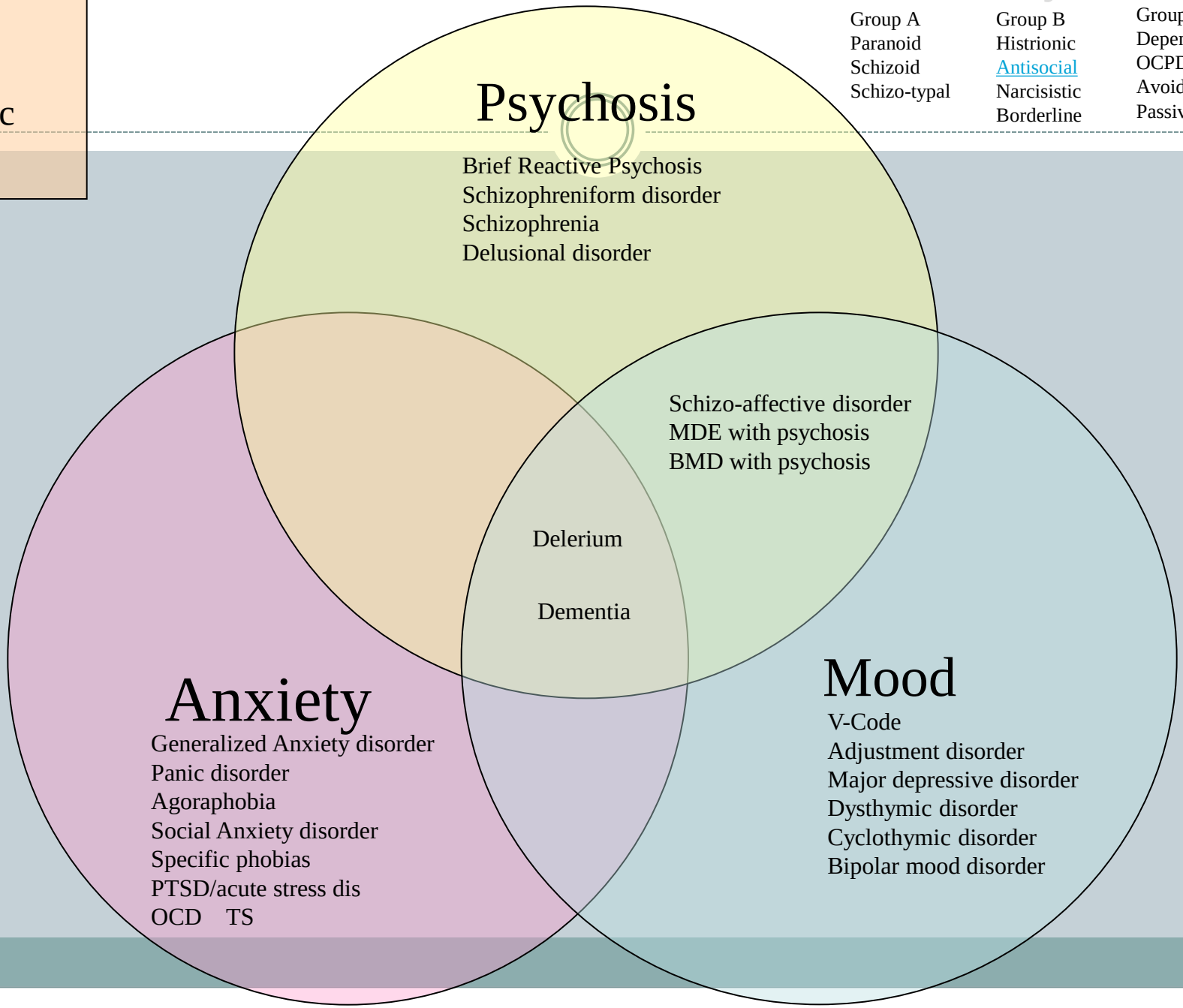
- Mental Health more than absence of mental illness
- Mother infant relationship
- Child's future mental health

Introduction: Psychiatric disorders

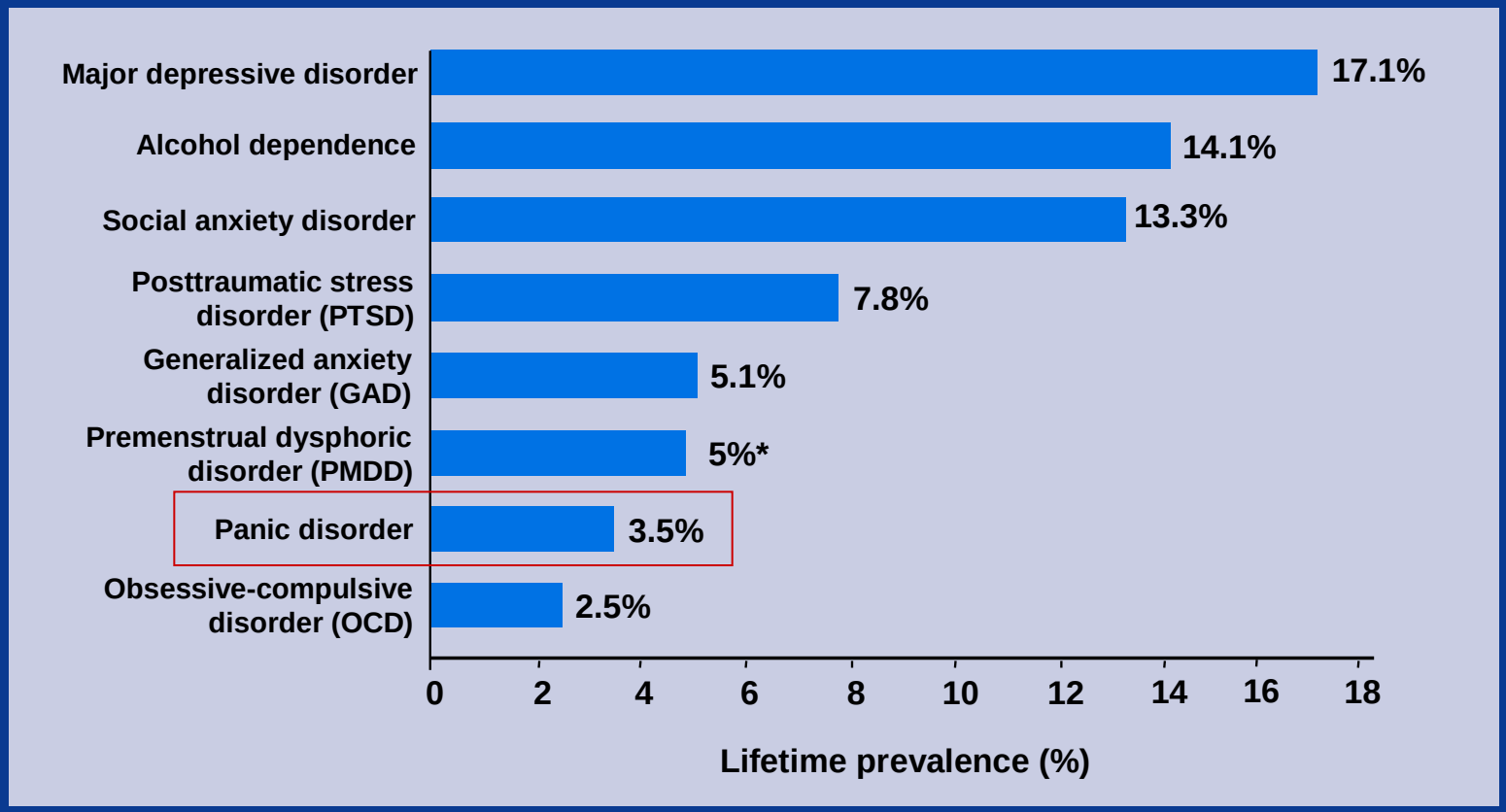
Sleep
Eat
Sex
Somatic
Drugs

Personality Disorders

Group A	Group B	Group C
Paranoid	Histrionic	Dependent
Schizoid	Antisocial	OCPD
Schizo-typal	Narcisistic	Avoidant
	Borderline	Passive-aggressive



Lifetime prevalence of common psychiatric disorders



*In menstruating women.

Kessler 1994; Kessler 1995; *DSM-IV-TR*™ 2000.

SASH study: Provincial lifetime prevalence estimates (%) of DSM-IV/CIDI disorders by province (*p<0.05)

Province	All disorders	Specific disorders (grouped) Anxiety	Mood	Substance use	Impulse	Sample size (*N*)
Western Cape	39.4*	18.9	13.7	20.6*	4.5*	448
Free State	37.5	21.5*	14.6*	15.5	3.3	421
North West	34.0	17.2	8.1	16.2	1.7	453
Limpopo	30.8	16.3	6.3*	13.5	2.6	420
KwaZulu-Natal	28.0	12.9	9.0	12.8	2.1	749
Gauteng	29.8	15.7	10.2	12.3	5.4*	593
Mpumalanga	29.2	16.0	9.0	9.1	0.1*	415
Eastern Cape	25.7*	13.3	8.3	8.5*	1.1	619
Northern Cape	28.7	15.0	7.7	13.8	3.8*	233
South Africa	30.8	15.8	9.7	13.3	3.0	4 351

Anxiety Disorders

Defining anxiety

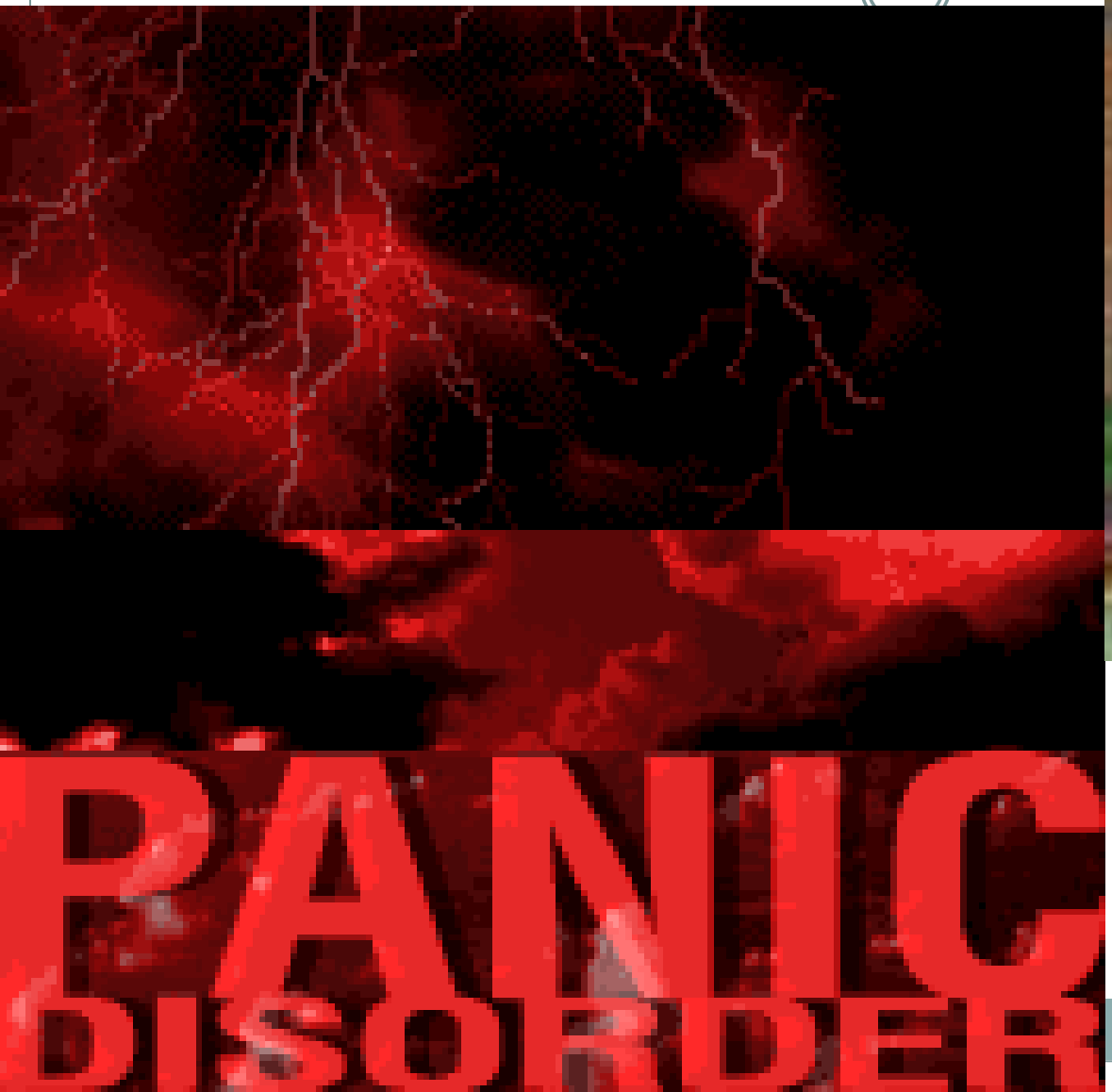
- **Anxiety & fear: Normal emotion**
- **Symptoms: Psychological/physical/mixture**
- **Several disorders within overall spectrum of anxiety disorders**
  - **Each own characteristic symptoms**
- **Intervention needed:**
  - **Disabling symptoms / reduce quality of life**

Impact of anxiety disorders

- **IT IS COMMON**
  - **Lifetime prevalence 25%**
  - **12 month prevalence 17.7%**
- **IT AFFECTS LIVES (Functional impairment)**
- **IT LEADS TO MORE PROBLEMS**
  - **Co-morbidity (other anxiety disorders, depression, substance abuse/ dependence) 85-90%; Mortality (suicide)**
- **IT HAPPENS AGAIN & AGAIN (Chronic course)**
- **IT IS OFTEN NOT RECOGNIZED BY PATIENTS (Time delay before seeking treatment)**
- **SOMETIMES NOT RECOGNIZED BY HEALTH CARE WORKERS**

A selection of Anxiety disorders from the DSM-IV-TR

- Panic disorder with/without agoraphobia
- Specific phobia
- Social phobia/ Social anxiety disorder
- Obsessive compulsive disorder
- Posttraumatic stress disorder
- Generalised anxiety disorder
- NOTE: DSM5 released May 2013


PANIC
DISORDER


PANIC

DSM-IV definition: Panic Disorder

- **Recurrent & unexpected panic attacks**
- **Panic attack: A discrete period of intense fear or discomfort that develops abruptly and reaches its peak within 10 minutes**
- **Accompanied by at least 4 somatic symptoms**
- **At least one of the attacks is followed by at least one month of:**
    a) **persistent concern about a future attack**
    b) **worry about the implications of an attack**
    c) **significant behavioral change resulting from an attack**

Agoraphobia

DSM-IV Definition: Agoraphobia

- **Agoraphobia:**
  - **Irrational fear of places or situations from which escape may be difficult or embarrassing if –**
    - **A situational predisposed panic attack was to occur**
    - **Leading to avoidance (numerous situations)**
- **Not related to the direct effect of a substance or a general medical condition**

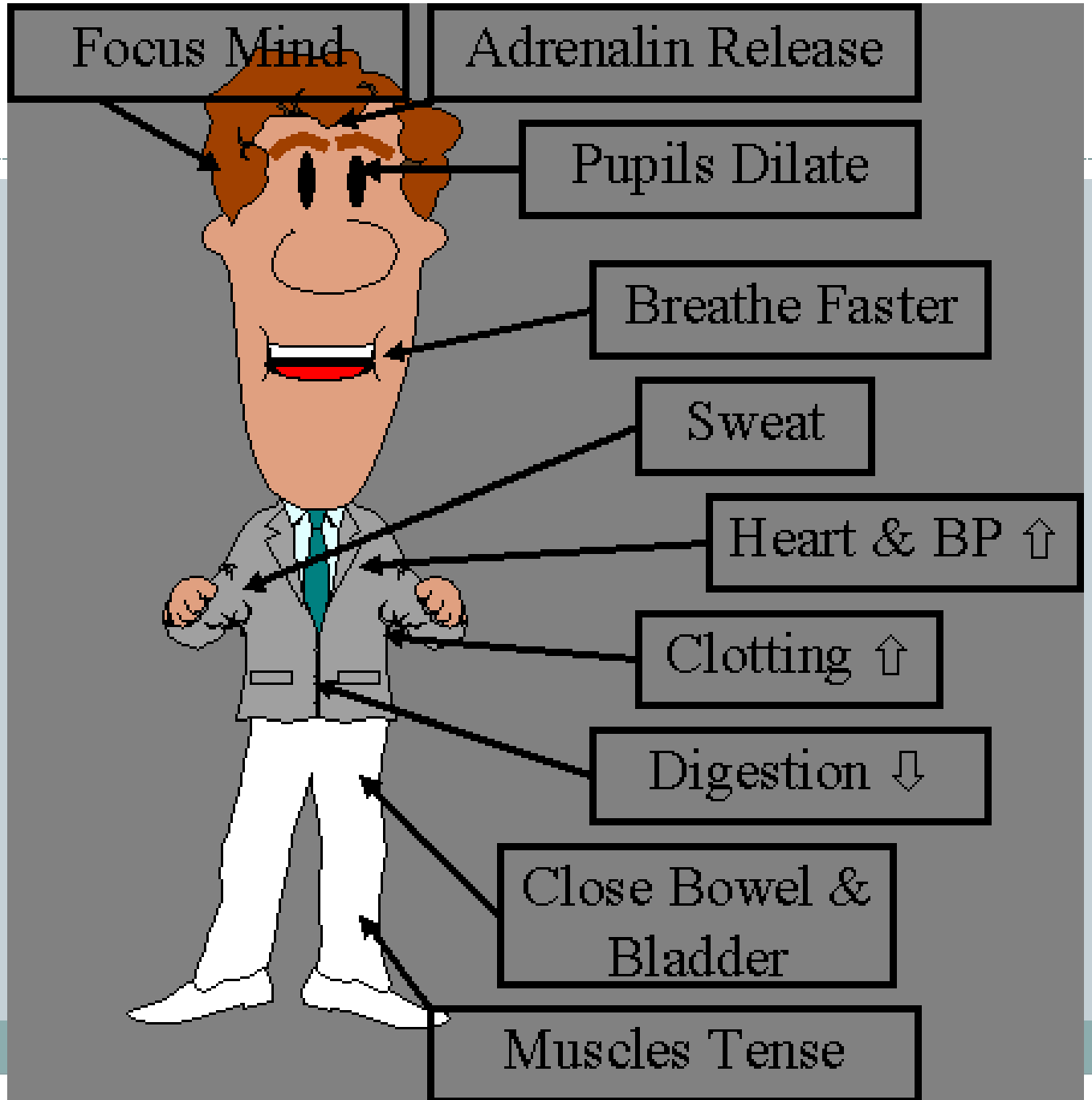
P

A

N

I

C


Focus Mind
Adrenalin Release
Pupils Dilate
Breathe Faster
Sweat
Heart & BP ⇧
Clotting ⇧
Digestion ⇩
Close Bowel & Bladder
Muscles Tense

Associated with physical symptoms

- Dyspnea
- Tachycardia
- Dizziness
- Paresthesiae
- Tightness/pain in
- chest
- Suffocation
- Faintness
- Perspiration
- Tremor
- Urinary/fecal urgency
- Dry mouth
- Muscle tension
- Nausea
- Visual disturbances
- Hot/cold flushes
- Derealization/ depersonalization

Panic disorder with/without Agoraphobia

Epidemiology

- **Lifetime prevalence of panic disorder (with or without agoraphobia): as high as 3.5% in community samples**
- **Age at onset: typically 15 -34 years**
- **Women at least twice as likely to be affected**
- **First degree relatives of patients with panic disorder are up to 8 times more likely to develop panic disorder**

Specific phobia

- Disproportionate fear of specific object or situation for example:
  - Animal
  - Natural environment
  - Blood, injections, injuries
  - Specific situations
    - (e.g. flying, elevators)
  - Diverse group

Social phobia/ Social anxiety disorder

- Disproportionate fear of negative evaluation (humiliation/ embarrassment) by other persons in social- or performance-bound situation
- Avoid situations if possible
- Recognizes fears are excessive
- Functional impairment

Obsessive compulsive disorder

- Obsessions:
  - Recurrent and persistent thoughts that are experienced as intrusive and inappropriate
  - Cause marked anxiety or distress
  - Tries to ignore or suppress
- Compulsions:
  - Repetitive and excessive behaviors, mental acts that person feels driven to perform in response to obsession or according to rules that must be applied rigidly

OCD

Obsessive compulsive disorder

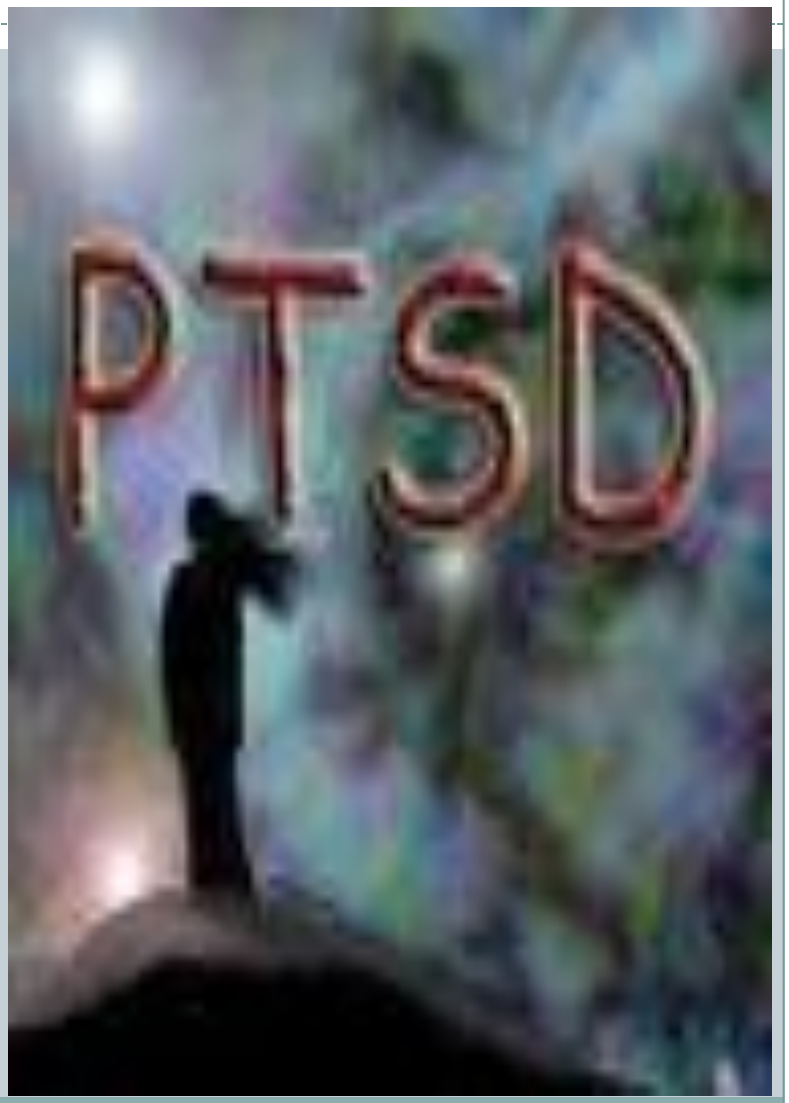
- **Obsessions**
  - Contamination concerns
  - Pathological doubt
  - Symmetry concerns
  - Scrupulosity
- **Compulsions**
  - Washing, showering
  - Checking locks, stove
  - Symmetry & precision
  - Prayer, confession

Obsessive compulsive disorder

- **Myth**
- OCD is rare disorder, seen only by a few specialists
- OCD is caused by underlying psychological conflicts
- OCD is best treated by psychoanalytic psychotherapy
- Treatment-refractory, has poor prognosis

- **Fact**
- High prevalence, frequently seen by GPs
- Specific neurochemical and neuroanatomic mechanisms involved i.e. brain disorder
- Responds to treatment
- Effective treatments has markedly improved prognosis

Post-traumatic Stress disorder



Post-traumatic stress disorder

- Exposure to extreme stressor
- Response with intense fear, helplessness, horror
- Set of symptoms for at least 1 month
  - Re-experiencing traumatic event via intrusive memories, dreams, flashbacks
  - Physical/ emotional avoidance of stimuli assoc with trauma/ numbing of emotions
  - Persisting symptoms of increased arousal
- Cause significant distress or functional impairment
- May develop months or years after event.

Generalised Anxiety Disorder

- Excessive and pervasive worry
- Associated with various somatic symptoms
  - Restlessness/ feeling of tension
  - Inability to concentrate
  - Exhaustible
  - Irritable
  - Muscle tension
  - Sleep disturbance
- Causes functional impairment and marked distress
- Lasts at least 6 months

Differential diagnosis: Anxiety Disorders

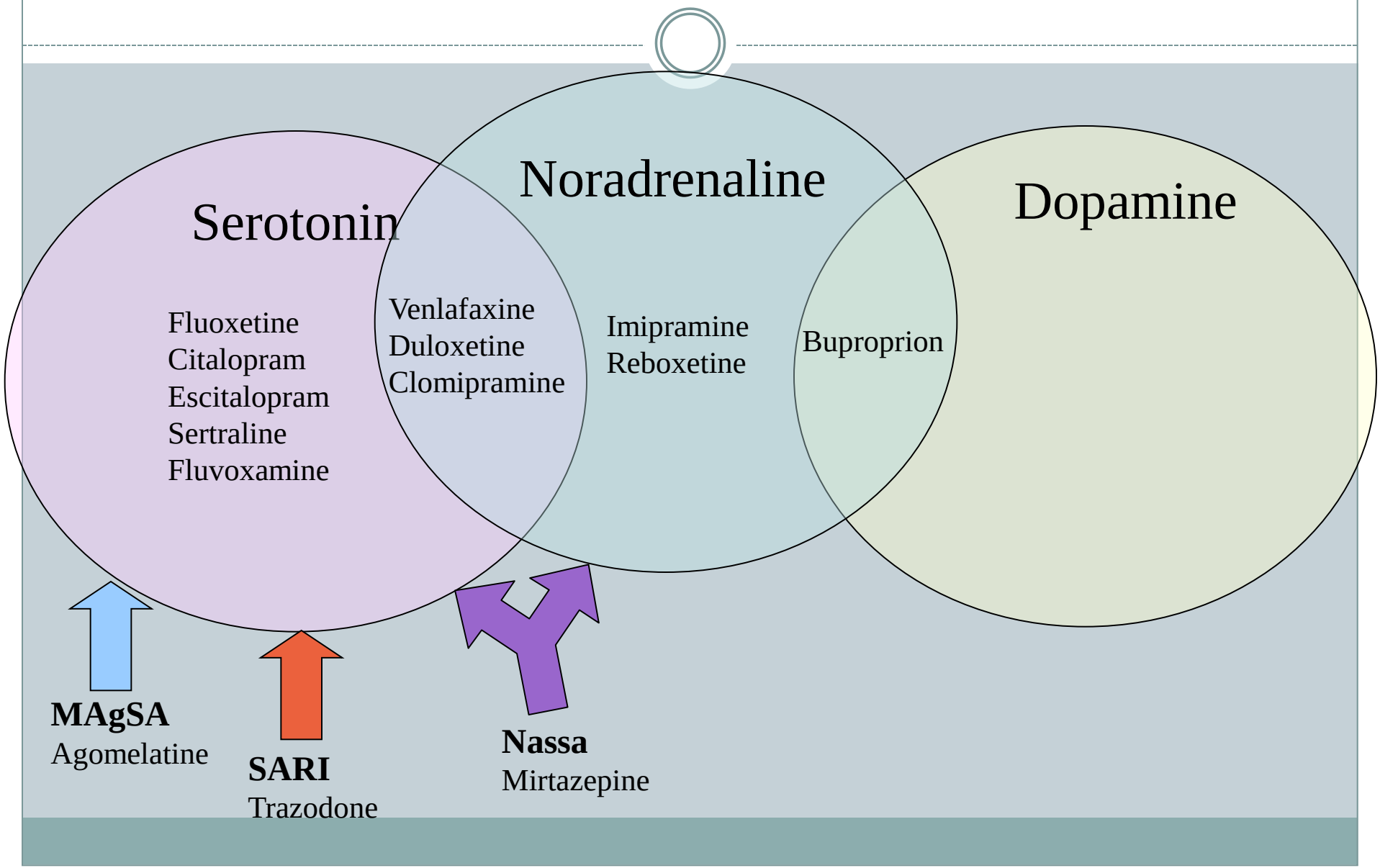
- **Medical illness**
- **Substances**
- **Psychiatric illness**

Treatment principles for anxiety disorders

- GP/ER: Exclude medical condition /substances
- Psychiatrist:
  - Full psychiatric assessment
  - Diagnosis
  - Further investigations if needed
  - Psychoeducation
  - Agree on management plan: Medication and/or CBT, Anxiety management (relaxation techniques)
- Psychologist, Pastoral psychologist: CBT
- Occupational therapist/ Physiotherapist
- Psychosocial support

ABC of Antidepressants

MAOI / RIMA
Phenelzine
Moclobemide



Treatments

Pharmacotherapy

- SSRIs (Prozac®, Cilift®, Cipralex®, Serlife®…)
- SNRIs (Venlor®/ Effexor®)
- Others

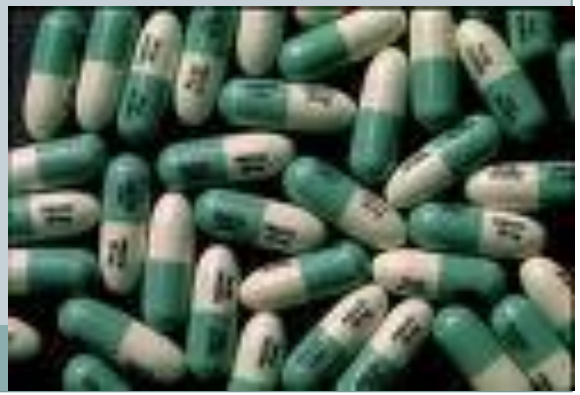
- **Psychotherapy**
  - Cognitive and behavioural
- **Psychoeducation**
- **Psychosocial support**
- **Lifestyle changes (diet, exercise, avoid caffeine/ stimulants, sleep hygiene)**

Pharmacotherapy

- Medications may increase anxiety initially
- “Start low, go slow, end high”
- Side-effects often improve after a few weeks of treatment
- Duration of treatment: Varies (at least 12 months anxiety free)
- Slowly reduce and stop medication under guidance of Psychiatrist
- Pregnancy/ Post-partum: Individualise every case; Risk-Benefit assessment; Psychotherapy may be first-line treatment in many cases

Benzodiazepines (Tranquilizers)

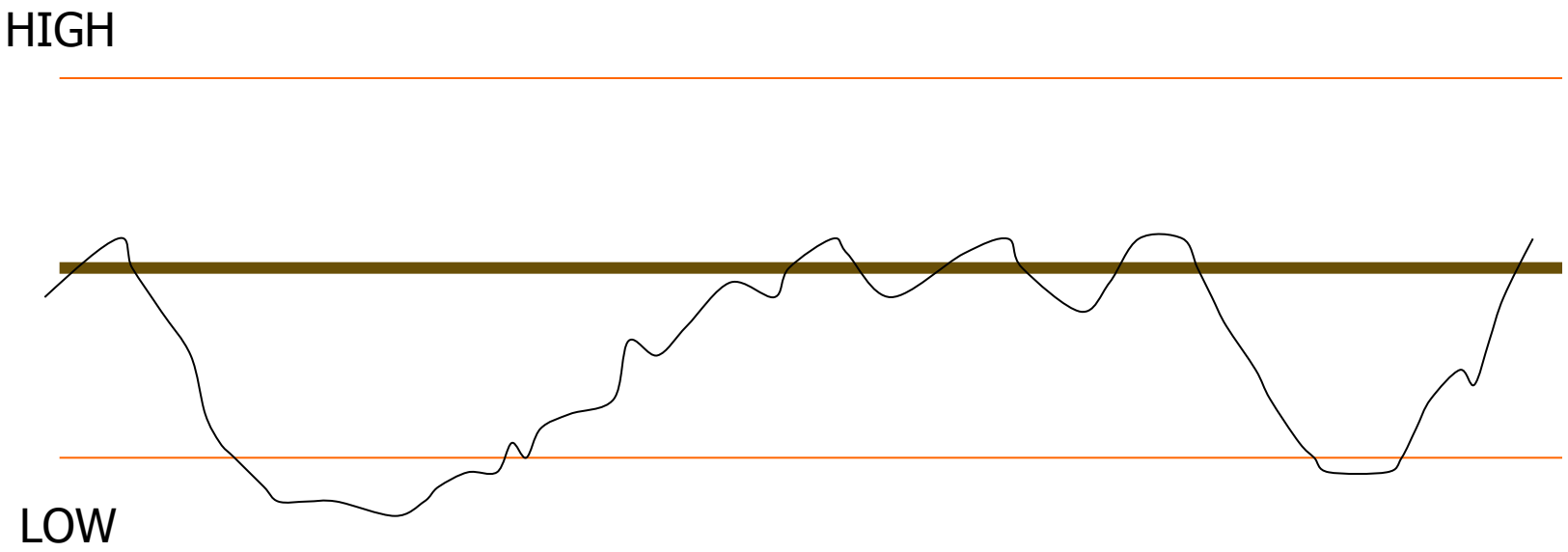
- Valium®, Ativan®, Alzam®, Xanor®, Pax®, etc.
- Rapid symptomatic relief from acute anxiety
- First few weeks (short course) benzodiazepines to control severe, disabling anxiety while initiating medium/long-term treatment (e.g. SSRI/SNRI)
- Not the mainstay treatment for anxiety disorders!
- AVOID in pregnancy and Breastfeeding if possible



MOOD DISORDERS

- MAJOR DEPRESSIVE DISORDER

What is Unipolar Depression?



Major Depressive Disorder

- DEPRESSION may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods.
- True clinical depression is a mood disorder in which feelings of sadness, loss, anger, guilt or frustration interfere with everyday life for at least 2 weeks

Causes, incidence, and risk factors

- The exact cause of depression is not known.
  - chemical changes in the brain.
    - Genetic susceptibility
    - Triggered by certain stressful events
    - Combination of both

- Some types of depression run in families. Depression can also occur if no family history of the illness.
- Anyone can develop depression, even kids.

Concentration

Interest

Pleasure

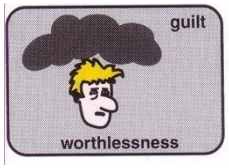
Psychomotor

Fatigue

Guilt

Suicidality

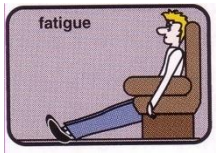
Mood



Pleasure

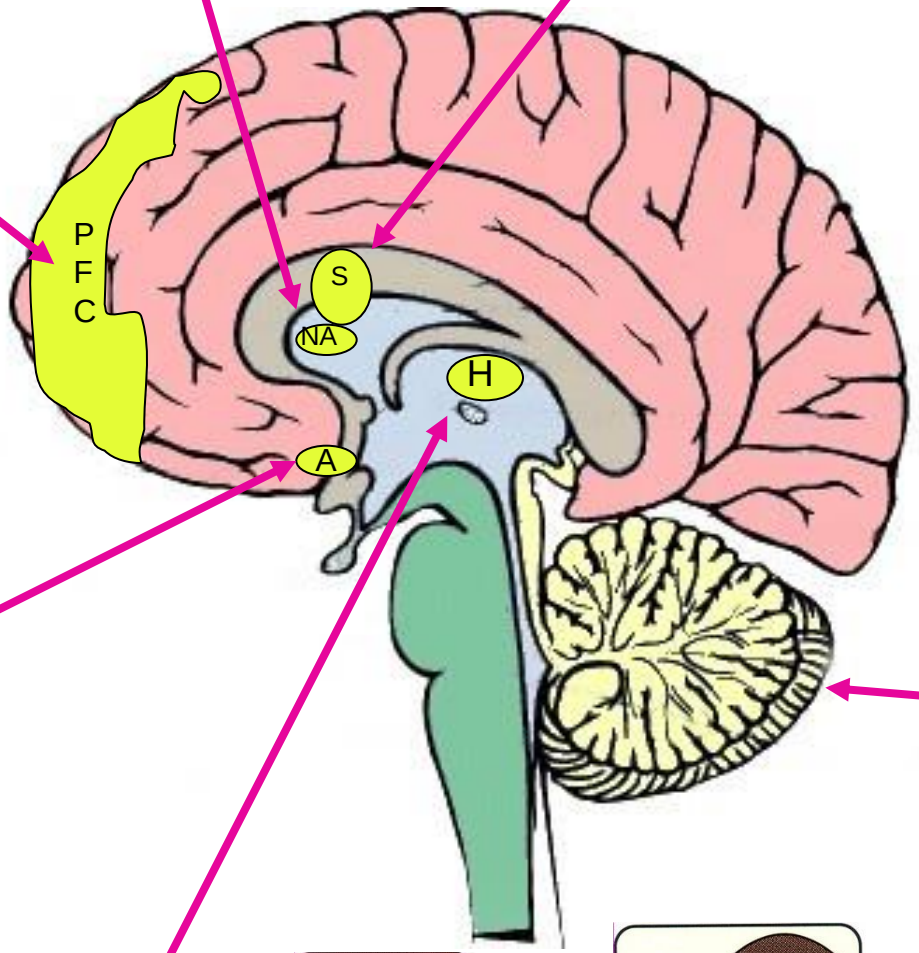
Interests

Fatigue/energy



Psychomotor

Fatigue (physical)

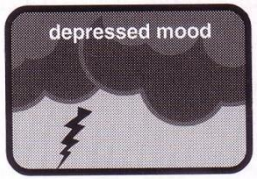


Guilt

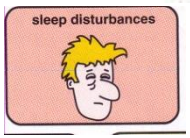
Suicidality

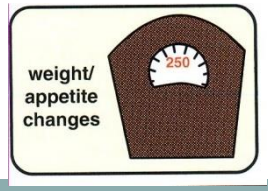
Worthlessness

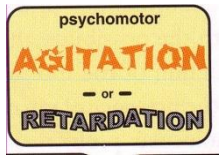
Mood



Sleep & appetite







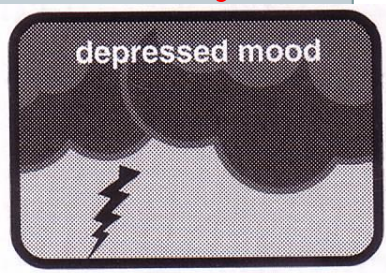
Psychomotor

Causes and risk factors

- The following may play a role in depression:
- Alcohol or drug abuse
- Certain medical conditions, including under active thyroid, cancer, or long-term pain
- Certain medications such as steroids
- Sleeping problems
- Stressful life events, such as:
  - Breaking up with a boyfriend or girlfriend
  - Death or illness of someone close to you
  - Divorce
  - Childhood abuse or neglect
  - Job loss
  - Social isolation (common in the elderly)

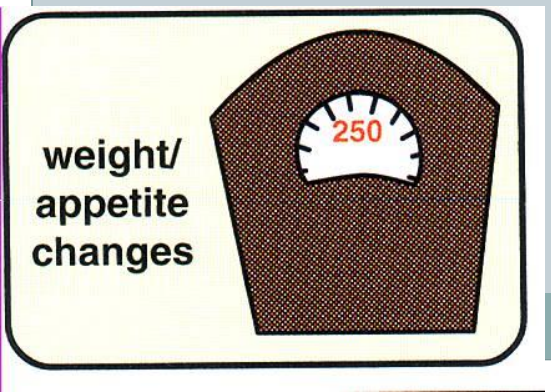
Symptoms of Depression

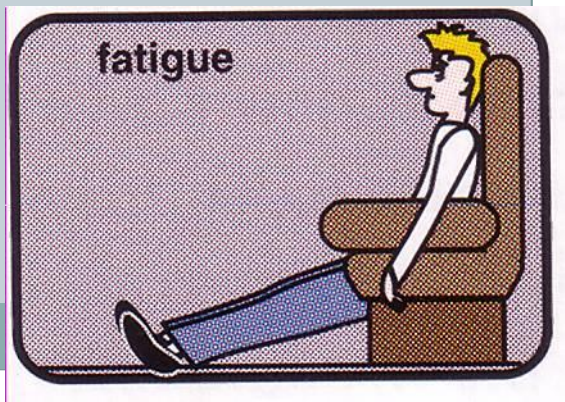
- Depression can change or distort the way someone see themselves, their life, and those around them
- People who have depression usually see everything with a more negative attitude, unable to imagine that any problem or situation can be solved in a positive way.
- Challenges of pregnancy and post-partum period even more difficult to face if depressed
- Post-partum depression interfere with mother-baby interaction and bonding



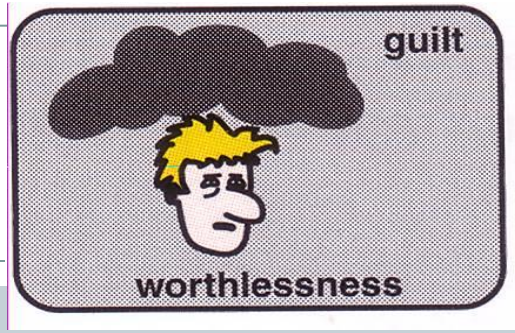
Symptoms of Depression

- Agitation, restlessness, and irritability, psychomotor retardation
- Dramatic change in appetite, often with weight gain or loss
- Very difficult to concentrate
- Fatigue and lack of energy
- Feelings of hopelessness and helplessness

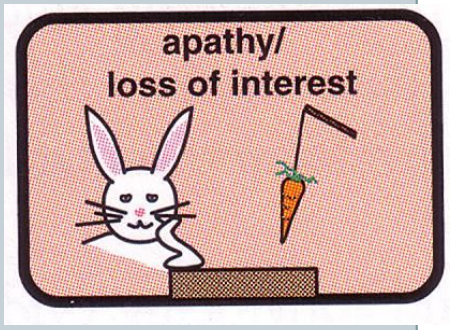


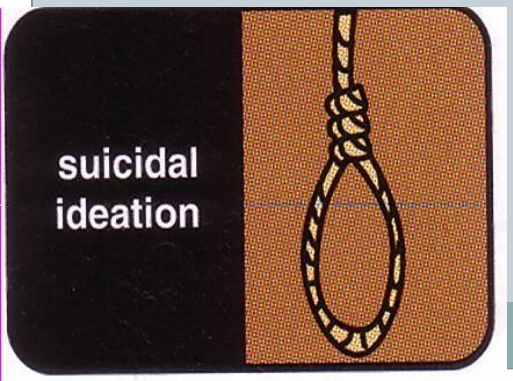


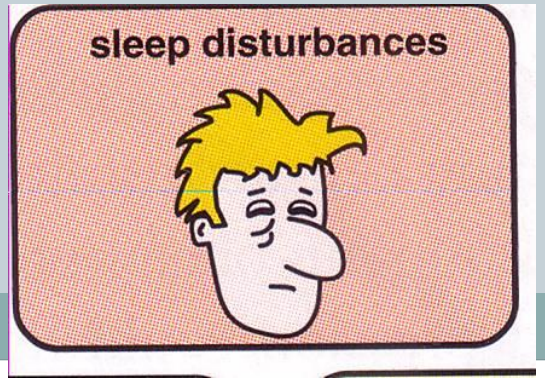
Symptoms



- Feelings of worthlessness, self-hate, and guilt
- Becoming withdrawn or isolated
- Loss of interest or pleasure in activities that were once enjoyed
- Thoughts of death or suicide
- Trouble sleeping or excessive sleeping







Symptoms of Depression

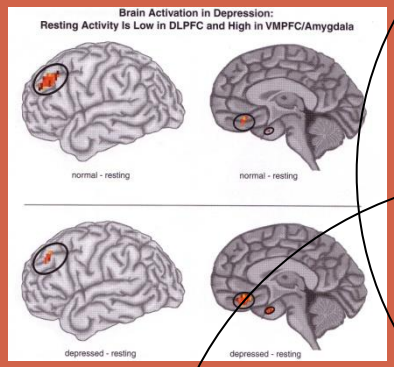
- Depression can appear as anger and discouragement, rather than feelings of sadness.
- If depression is very severe, there may also be psychotic symptoms, such as hallucinations and delusions.
- Risk to self and baby

Management: Depression

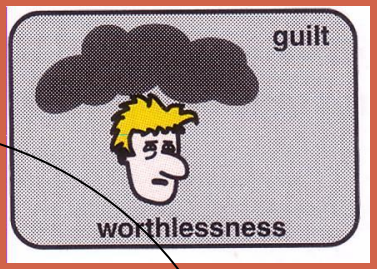
- If depression is suspected in client:
- Referral to GP or Psychiatrist for assessment, blood tests if needed, diagnosis, psycho-education and treatment

The Bio-Psycho-Social Model

BIOLOGICAL



PSYCHOLOGICAL



SOCIAL

SPIRITUALITY

Treatment: Depression

- In general, treatments for depression include:
- Medications called antidepressants
- Talk therapy, called psychotherapy

Treatment: Depression

- Mild depression: Psychotherapy/Medication
- More severe depression: Usually combination of both treatments.
- Takes time to feel better, but there are usually day-to-day improvements.
- If someone is suicidal or extremely depressed and cannot function or the safety of their baby is at risk, they may need to be treated in a psychiatric hospital.
- Some units allow babies to be with mom under nursing supervision

Antidepressants

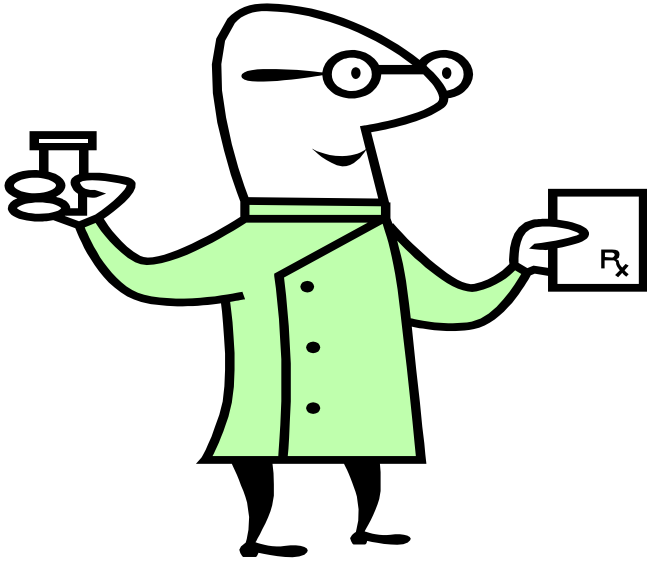
- Selective serotonin re-uptake inhibitors (SSRIs): Prozac®
- Serotonin norepinephrine reuptake inhibitors (SNRIs): Venlor®
- Other medicines include:
- Tricyclic antidepressants: Imipramine (Tofranil®)
- Mirtazepine (Remeron®)
- Bupropion (Wellbutrin®)
- Monoamine oxidase inhibitors

Antidepressants: the facts

- AD's are not addictive
- AD's have to be used for at least 6 months
- AD's do cause side effects
- AD's do not work in all patients
- AD's are NOT tranquillizers

NB

Depression can be cured!



Treating depression in Pregnancy

- Untreated maternal depression are likely to be more harmful to the mother and baby's health than treating with antidepressants during pregnancy and breastfeeding
- Individual risk-benefit assessment
- Psychotherapy may be first line treatment in many cases
- Antidepressants such as sertraline and citalopram are relatively safe in breastfeeding

Other treatments for depression

- Electroconvulsive therapy (ECT) is the single most effective treatment for severe depression and it is generally safe. ECT may improve mood in those with severe depression or suicidal thoughts who don't get better with other treatments. It may also help treat depression in those who have psychotic symptoms.

Support groups

- Joining a support group of people who are sharing similar problems can be very helpful.

Complications: Untreated Mental Illness

- Alcohol or illegal substances abuse
- Increased risk of physical health problems
- Suicide
- Poor self-care and nutrition

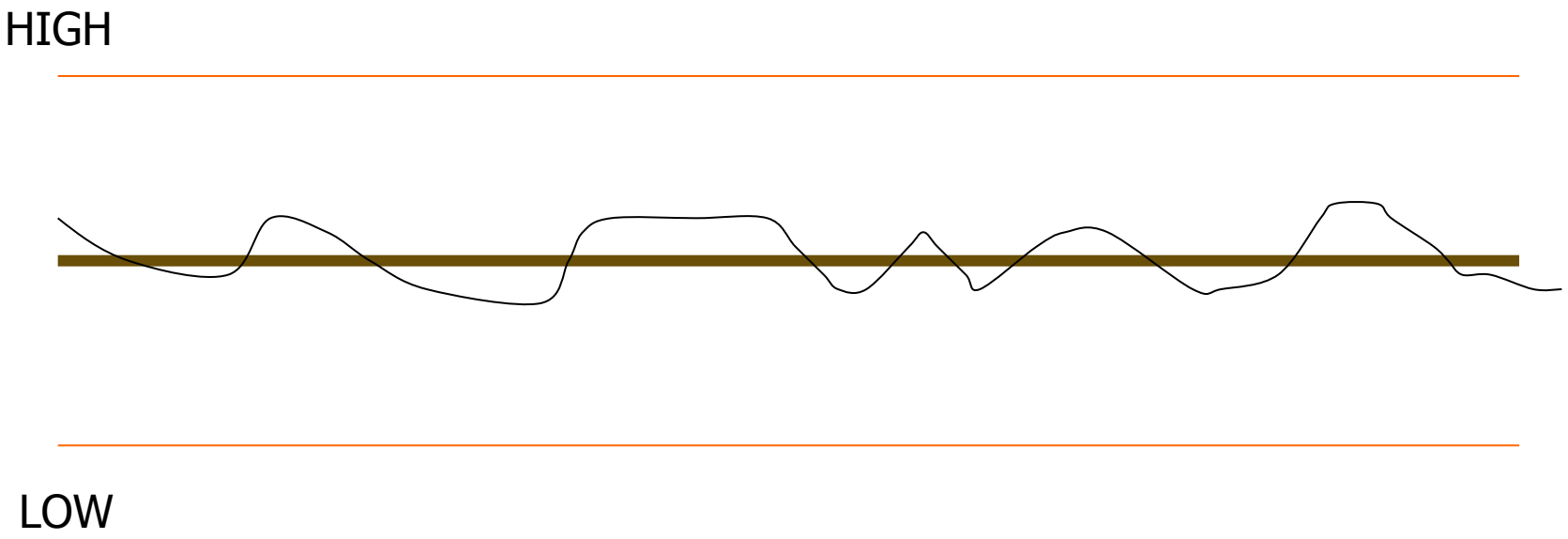
Lifestyle changes

- Get more exercise
- Maintain good sleep habits
- Seek out activities that bring you pleasure

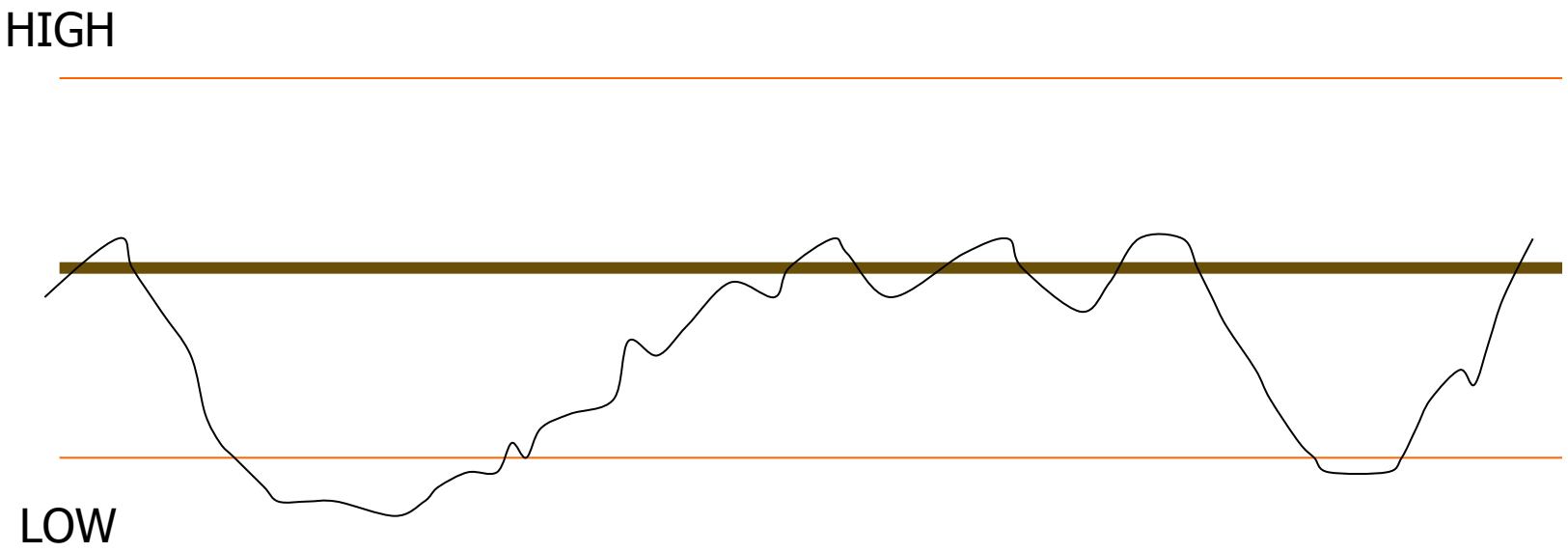
Bipolar disorder

PREVIOUSLY CALLED:
MANIC DEPRESSION
BIPOLAR MOOD DISORDER
BIPOLAR AFFECTIVE DISORDER

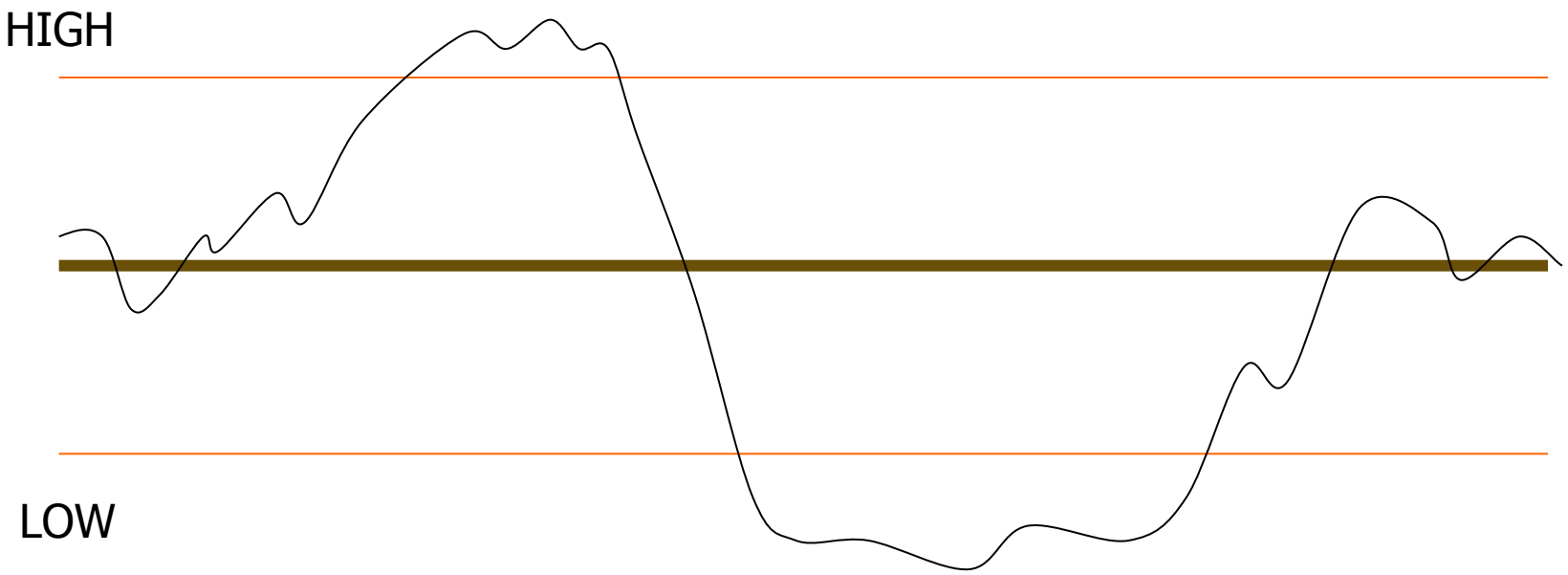
What is Normal Mood?



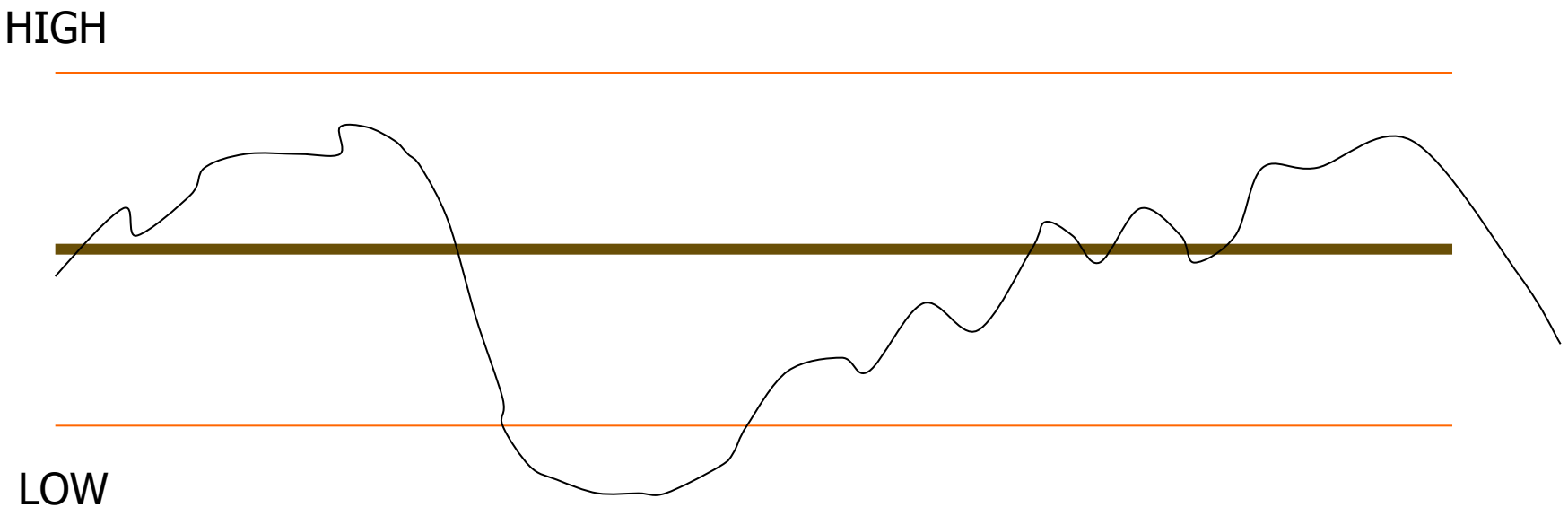
What Is UNIPOLAR DEPRESSION?



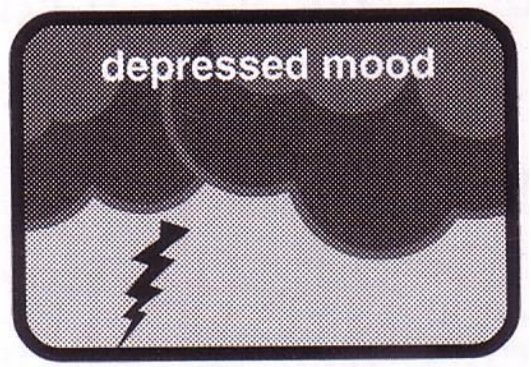
What is Bipolar I Disorder?

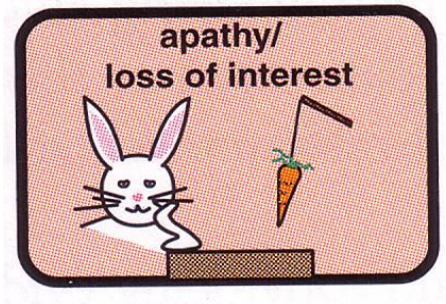


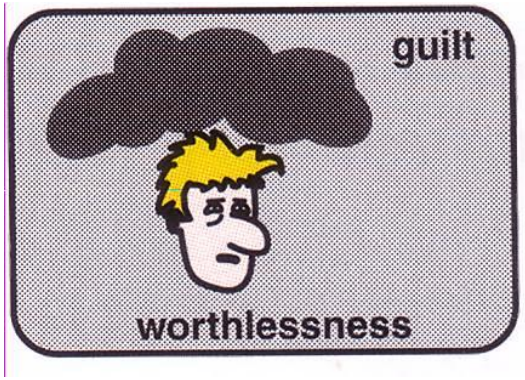
What's Bipolar II Disorder?

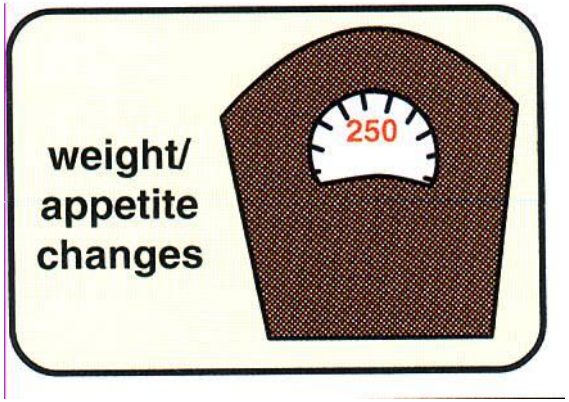


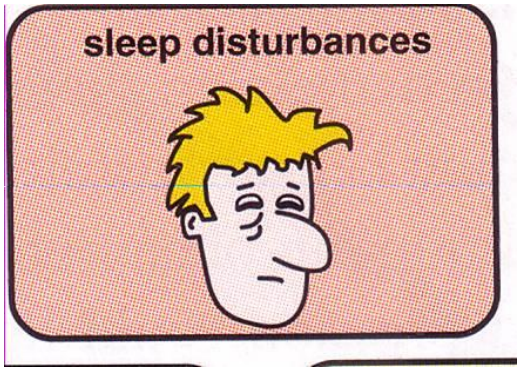
What is Depression?

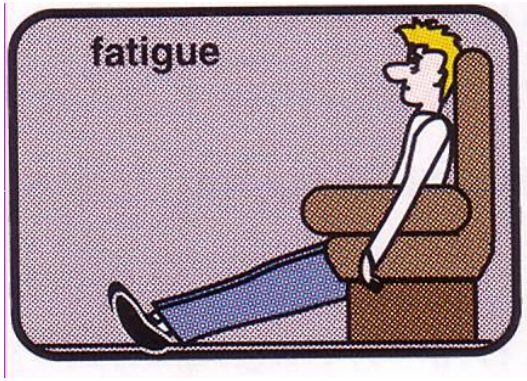


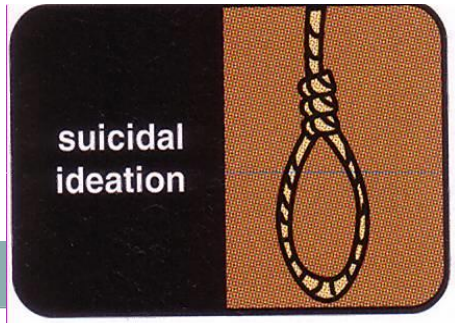






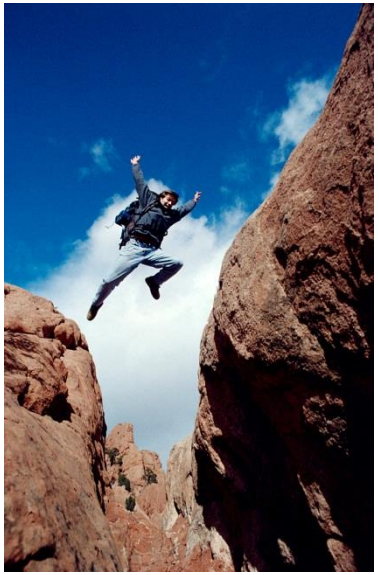






What is Mania?

Irresponsible behaviors



Feeling GREAT

Abnormal beliefs

Decreased need for sleep

Irritability

DSM-IV: Manic episode

- Abnormal, persistent elevated/irritable mood
- At least 1 week
- Grandiosity
- Decreased need for sleep
- Talkative, pressured speech
- Flight of ideas, racing thoughts
- Distractible
- Increased goal-directed activities/ agitation
- Excessive pleasurable activities, often with painful consequences
- Marked impairment / Hospitalisation / Psychosis

What is Hypomania?

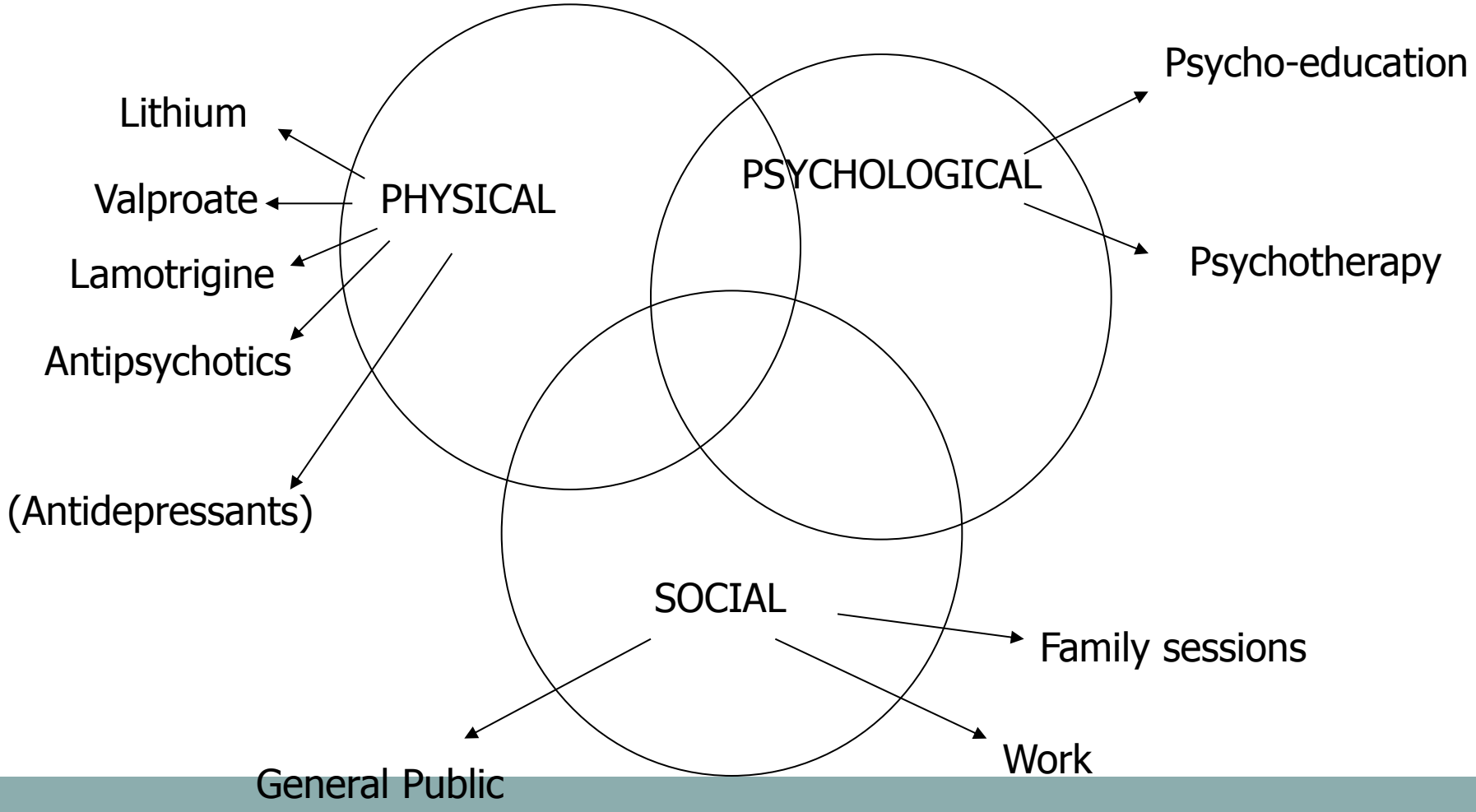
- Similar symptoms to mania
- Lasting at least 4 days
- No psychotic symptoms
- No hospitalisation needed
- Function not markedly impaired
- But Bipolar 2 disorder debilitating illness as patients often in prolonged severe depressive episodes

"My life is like a rollercoaster"

How do patients describe bipolar?

"I am in a deep well and feel as if I won't ever get out"

Treatment: Bipolar disorder



Bipolar disorder and pregnancy

Bipolar disorder and Pregnancy

- Planned pregnancy
  - Consultations with Patient and partner
  - Thorough individual risk-benefit assessment:
    - Assess psychiatric and medical illness history, treatment history, social support, current mental state and treatment, etc.
  - Discuss genetic risk, teratogenicity of medications, risk of relapse if medication stopped / changed
  - High risk of relapse post-partum (stress, irregular routine, sleep deprivation, changes in hormones and medication levels etc.)
  - Discuss other options (adoption, surrogacy)
  - Discuss family planning options

Bipolar disorder and pregnancy

- If patient decides to fall pregnant:
- Optimize general health (folic acid, nutrition, **no** smoking/alcohol/drugs of abuse)
- Support systems in place if mom needs admission
- Psychiatrist adjust medication prior to pregnancy to lower risk of teratogenicity
- Close monitoring during pregnancy by psychiatrist and high risk obstetric clinic (interdisciplinary collaboration NB)

Delivery considerations

- Liaise closely with obstetrician
- Hospital delivery
- Paediatrician and neonatal resuscitation available
- Adequate pain control; IV line - adequate hydration
- Stop lithium and benzodiazepines at onset of labour, recommence post delivery after checking levels

Post-partum considerations

- High risk for post natal depression/psychosis
- Allowing mom to rest/ sleep, limit visitors & excessive stimulation, limit stressful situations (e.g. moving house, renovations)
- Ensure adequate social support
- Breastfeeding

PNDSA
Post Natal Depression Support Association
SOUTH AFRICA

SMS
'HELP'
and your name
to
082 882 0072
and we'll
contact you

Bipolar disorder and pregnancy

- Unplanned pregnancy
- Urgent referral to psychiatrist and obstetrician
- Evaluation & discussion with patient (& partner) to do individual risk-benefit assessment.
- Management will depend on gestational age, whether TOP is considered, socio-economic situation, ultrasound findings, illness and treatment history, current mental state of patient etc.
- Interdisciplinary collaborative approach
- Do not stop psychiatric medication abruptly/randomly
- Monotherapy; Lowest effective dose
- FOLIC ACID, good nutrition, STOP substances of abuse/ alcohol/ smoking

Schizophrenia

I should Have Taken A Cab

What is Schizophrenia?

- Chronic, severe psychiatric / psychotic illness
- Approximately 1 percent of the population develops schizophrenia during their lifetime
- Affects men and women with equal frequency
- Often appears earlier in men
- Frequent recurrences, hospitalisations
- 80% unemployed
- Many homeless
- 10% commit suicide
- Few receive adequate treatment

What is Schizophrenia?

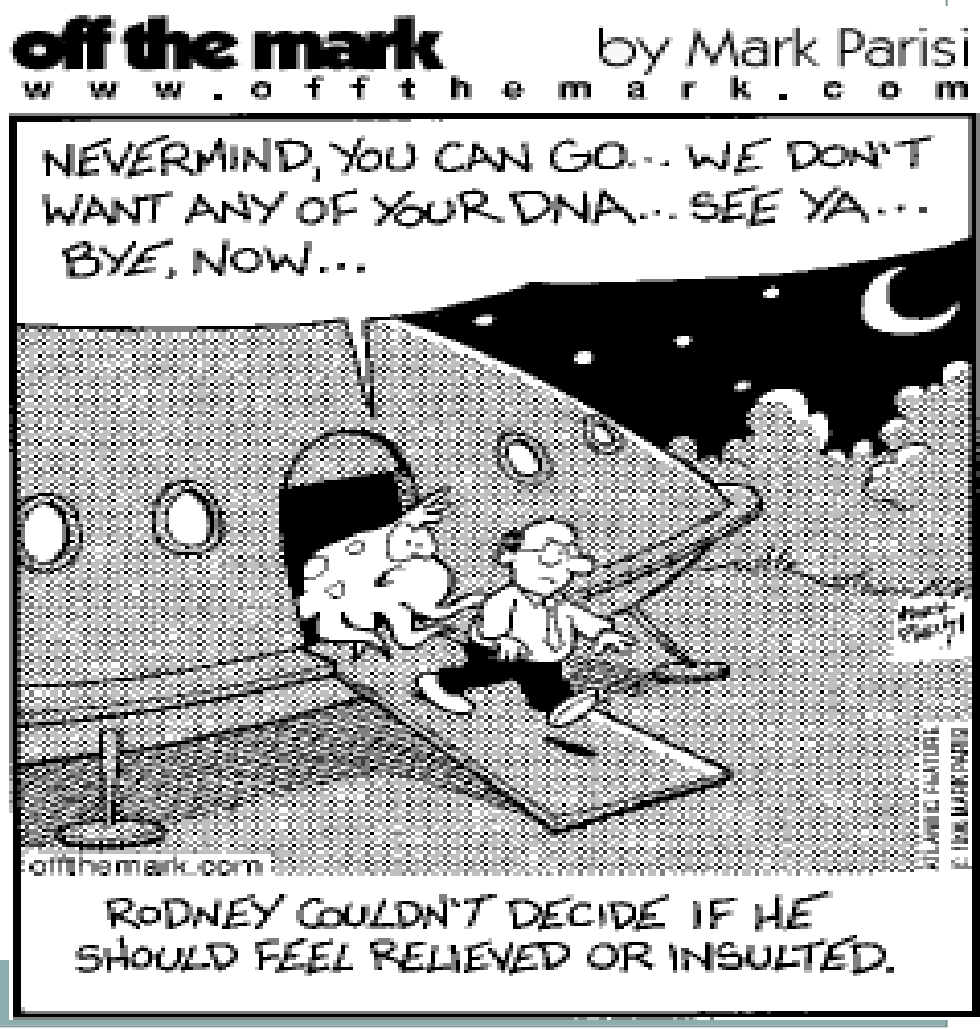
- Suffer terrifying psychotic symptoms
  - hearing internal voices not heard by others
  - believing that other people are reading their minds, controlling their thoughts, or plotting to harm them
  - symptoms may leave them fearful and withdrawn
  - speech and behavior can be so disorganized that they may be incomprehensible or frightening to others.

What is Psychosis?

- State of mental impairment marked by
  - hallucinations (disturbances of sensory perception)
  - and/or delusions, (false yet strongly held personal beliefs that result from an inability to separate real from unreal experiences)
- Less obvious symptoms, such as social isolation or withdrawal, or unusual speech, thinking, or behavior, may precede, be seen along with, or follow the psychotic symptoms.

Causes: Schizophrenia

- **MULTIFACTORIAL**
- **Genetic**
- **Biochemical**
  - **Dopamine**
  - **Serotonin**
  - **Glutamate**
- **Neurological**
  - **Degenerative**
  - **Developmental**



DSM-IV Diagnosis: Schizophrenia

- At least two of the following
  1) Delusions
  2) Hallucinations
  3) Disorganized behavior
  4) Disorganized speech
  5) Negative symptoms

  Positive Symptoms
- For at least one month
- Decrease in functioning for at least 6 months
- Mood symptoms, if present, onset after psychosis and short duration
- Not due to substances or GMC

Treatment: Schizophrenia

- **Acute ANTIPSYCHOTIC** treatment
- **Maintenance ANTIPSYCHOTICS**
- **FAMILY** intervention
- **PSYCHOSOCIAL REHABILITATION**
- **SKILLS** training
- Supported **EMPLOYMENT**
- Cognitive behaviourally oriented **PSYCHOTHERAPY**
- **COMPLIANCE** therapy
- **ASSERTIVE COMMUNITY TREATMENT**

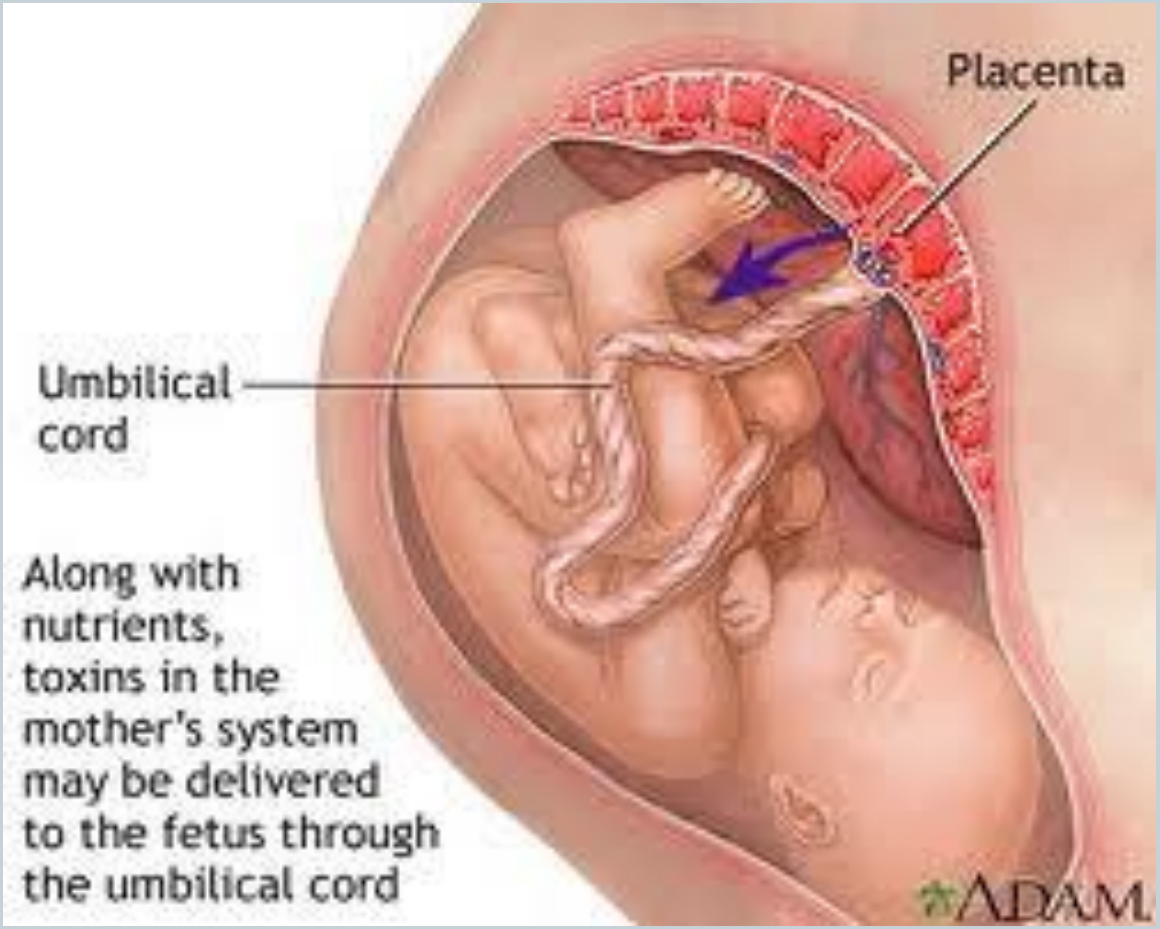
Treatment: Medication

- Antipsychotic medications have greatly improved the outlook for individual patients.
- These medications reduce the psychotic symptoms of schizophrenia and usually allow the patient to function more effectively and appropriately.
- Antipsychotic drugs are the best treatment now available, but they do not cure schizophrenia or ensure that there will be no further psychotic episodes.

Schizophrenia and Pregnancy

- Similar approach than Bipolar disorder
- Generally, antipsychotics have lower risk of teratogenicity than moodstabilizers during pregnancy

Substance Use Disorders In Pregnancy



Substance Use

- ETOH
  - 1/4 preconception
  - 71% stopped when pregnancy recognition (often well into 1st trimester)
  - MDD associated with ETOH use
  - Increase smoking, STD, intimate partner violence
  - FAS
- Nicotine
  - largest preventable cause of death (UK)
  - mentally ill more likely to smoke
  - LBW, Prematurity, SIDS, ADHD

Chang 2008, May 2009, Mary J. O'Connor 2011

The Perinatal Illness Spectrum

Perinatal Disorders

- Pregnancy and postpartum
- Mood disorders
- Anxiety Disorders
- Psychosis

Normal Mood Changes in Pregnancy and Postpartum

- Labile mood common, normal
- A certain degree of heightened anxiety – normal
- Post delivery – baby blues 3 -5 days
  - resolves spontaneously

Baby blues

- Normal
- More than 90% of women
- 3-5 days
- Should
  - Resolve in 2 weeks
  - Not interfere with functioning

So what's abnormal?

- Persistent changes in mood
- Incapacitating anxiety
- Inability to function
- Numbing, inability to feel
- Suicidal, homicidal thoughts

Perinatal Mood Disorders

- Common – 1 in 10 women
- Usually depressed mood
- Often starts in pregnancy – 21% pregnant women
- Carries on into postpartum
- Consequences for mother and child
  - Poorer growth and development
  - Attachment?

Perinatal Anxiety

- May be more common than depression
- Again often starts in pregnancy
- Biggest risk factor for depression
- Concerns around baby

Perinatal Distress

- More useful than depression/anxiety
- Often mixed picture
- Sleep disturbance
  - Can't sleep even when baby does
- Impairment in function
- Degree of distress
- Suicidal/homicidal ideation

Postpartum Psychosis

- Rare < 1% women
- Most often affective (mooddisorder) psychosis
- Serious – mother at high risk to herself and baby
- Labile, restless, agitated
- Delusions around child
- May be homicidal toward child
- Recognise and refer promptly

Who is at risk?

- Previous Psychiatric Illness
- History of Illness in current pregnancy/past pregnancy
- Unwanted child
- Poor social support
- Substance use

Postpartum OCD

- OCD
  - Obsessions
  - Compulsions
- Not common 1-2%
- Revolves around child, germs
- Hormonal role

Postpartum OCD 2

- Features of OCD common in depression
- Suspect when:
  - Prominent obsessions or compulsions
  - Past history
  - Failure to respond to treatment
- Refer to Psychiatrist

Summary

- Spectrum illness
- Perinatal distress useful concept
- Key features
  - Function
  - Level of distress
  - Self harm/harm to baby

Perinatal Distress Treatment

How to treat

- **Recognise cases**
- **Screen women**
- **Assess risk to mum and baby**
- Refer
  - Psychiatrist
  - Clinic – advice on baby, feeding
  - Support groups
- Mobilise social support
- Destigmatise

Screening

- Best way to recognise cases
- Ideal
  - Screen all women
  - Several times in pregnancy and postnatally

Screening tools

- Edinburgh Post-natal Depression Scale (EPDS)
  - Score > 10 indicates possible depression
- Patient Health Questionnaire 9 (PHQ-9)
  - Score > 10

PHQ-9 scoring

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____ **DATE:** _____

Over the *last 2 weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3
add columns:		+	+	
(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card.)			**TOTAL:**	

Treatment

- Holistic approach
- Psychological
- Social
- Medication

Psychological treatments

- ANY psychotherapy effective in short term for mild to moderate depression
- Stand alone therapy mild to moderate illness
- Combination with medication if more severe depression or if psychotherapy alone not effective

Medication

- Generally SSRI's and TCA's antidepressants are safe in pregnancy and breastfeeding
- Antipsychotics – reasonably safe
- Mood stabilisers – teratogenicity risk
- ECT – option

SSRI's

- First line pharmacotherapy
- No increase in the rates of major congenital malformations in infants exposed to SSRI's,with the exception of paroxetine
- No long term behavioural effects

Benzodiazepines

- Small increased risk for cardiac/oral cleft malformations with first-trimester exposure.
- Neonatal toxicity (“floppy infant syndrome”) /withdrawal
- Avoid in the first trimester, late in the third trimester
- To minimize neonatal withdrawal, gradually taper the mother’s benzodiazepine before delivery
  - Taper 3 to 4 weeks before the due date and discontinue at least 1 week before delivery.
  - If benzodiazepines cannot be tapered
    - use a short acting agent
    - advise the mother to discontinue benzodiazepine use as soon as she thinks she is going into labour.

Breastfeeding and Medication

- MOST WOMEN ON MEDS CAN BREASTFEED!!!!!
- Risk of child dying from diarrhoea, respiratory disease, malnutrition higher than medication side effects
- Case by case basis

Breastfeeding - Balancing Risk

- Best nutrition
- Immunoprotective
- HIV?
- Breastfeeding more than milk

Eglonyl?

- Sulpiride
- Antipsychotic with theoretical mood elevation properties at low doses
- Side effect of increasing milk supply
- Sedating
- NOT an effective antidepressant

Support

- SUPPORT = KEY!!!
- Engage with therapy
- Compliance on medication
- Mediate with other health professionals
- Breastfeeding/feeding

Family Support

- Partner and family
- Psycho –education
- Practical advice
- Importance of sleep

Happy Mom, Happy Baby

- Advice expecting mothers:
- Now and once baby is born
- Eat healthily
- Regular exercise
- Relaxation, quiet time, me time
- Prayer, spiritual practice
- A car cannot run on an empty tank NEITHER CAN YOU!

Conclusion

- Effective treatment for PND
- Holistic
- Support is key

PNDSA
Post Natal Depression Support Association
SOUTH AFRICA

SMS
'HELP'
and your name
to
082 882 0072
and we'll
contact you

Attachment

Mother-infant attachment

- A mother's bond with her child, especially during the peri-partum and early childhood phases of development, is probably the strongest human relationship that exists.
- Secure mother-child attachment during infancy leaves an invaluable legacy, not only to the child in his or her later years, but also to society as a whole.
- World Health Organization has singled out early attachment and bonding as important determinants of future mental health (WHO, 2004).

Mother-child attachment

- Definition: “The persistent and significant affectional bond that develops between a child and his or her caregiver.”
- Foundation for a ‘secure base’ from which the infant is able to engage in exploration of its environment and develop independence .
- Attachment security may promote the healthy development of the infant
- Insecure maternal attachment has been shown to be associated with infants’ failure to thrive
- Maternal mental disorders make infants particularly vulnerable to insecure maternal attachment

Mentalization

- Mentalization: One's ability to understand another's intentions, feelings, thoughts, desires and beliefs and to use that understanding to make sense of emotional processes.
- The development of structures responsible for self and affect regulation are facilitated by mentalization
- The capacity for which is operationalized by reflective functioning.
- In parents, this ability emerges as a function of the attuned reading and modulating of the child's internal state and creates an environment in which the child can develop an understanding of himself.

Reflective functioning

- The child's capacity to make sense of his internal experience depends largely on the parents' reflective capacity
- Failure in maternal reflective functioning will have a significant impact on the quality of attachment with the child as well as various areas of development and should increase the risk of the infant to develop major psychiatric disease.

Attachment

- Bowlby, 1969: “Innate behaviour system that enables infant to regulate closeness to his mother”
- Mother’s attachment style predicts infants response in 80% of cases
- Mirror neurons allows us understanding of other people’s intentions
- Attachment style is stable throughout life
- Insecure attachment patterns carries risk for difficulties with emotional development

Conclusion

Conclusion

- Mental health carries a huge burden
- Prevention and early intervention better than cure
- Vulnerability starts antenatal
- Importance of maternal mental health

Conclusion

- WHO: “No health without mental health”
- Focus on resilience (Protective factors)
  - Antenatal and postnatal maternal care
  - Relationships
  - Parenting
  - Social support
  - Access to resources
  - Employment

Thank you

QUESTIONS?