WHAT IS A PERINATAL PSYCHIATRIST, AND WHAT DO THEY DO?

An essay for the royal college of psychiatrists (2021)

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The question of 'what is a perinatal psychiatrist, and what do they do?' has doubtless been asked (perhaps frantically, whilst writing a referral letter) by many doctors other than those in the Royal College of Psychiatrists.

A philosophical and uniquely abstract specialty (1), psychiatry strives to unravel the nebulous interface between brain, mind and soul. As social animals, neurologically wired to live entwined with one another, much of a person's emotional balance rests upon the quality of their relationship to others.

Perhaps the most crucial (yet intangible) bond of all is that between mother and child. The formation of this intricate new relationship is a cross-cultural, recurring pastiche in religion, art, and scientific enquiry.

At what point does this union begin?

The 'perinatal period', which comprises pregnancy and the first year following childbirth, is recognised as extremely complex for the mother, and fraught with potential complications. The Royal College of Psychiatrists reports that around 1 in 5 women experience some mental health difficulty during this period; for example, 1 in 500 births result in puerperal psychosis, whilst 10-15% of mothers experience postnatal depression (importantly, this can also affect fathers).

Specialist support during this period (previously provided by a general psychiatrist) is now the remit of the perinatal psychiatrist.

This essay aims to explain the clinical, practical and abstract aspects of the perinatal psychiatrist's work. It will frame the role in light of its historical evolution, discussing how it operates today in the UK, and will touch upon the unique challenges of the specialty. It will consider the nature and significant burden of poor perinatal mental health, and consider what grave and surprising lessons have formed its foundations so far.

Finally, how does the PN psychiatrist serve such a rich cultural and ethinic diversity of patients in the UK today? How might the role evolve in the future, and how could a culturally-informed approach enrich practice in this essential and fascinating area?

Introduction
A horrific historical revolution

Perinatal psychiatric maladies have long attracted interest, scientific enquiry, and fatal misunderstanding. Women suffering from postnatal 'hysterias' in the 15th century were thought to be afflicted by evil spirits, prompting the role of their physician as 'spiritual guide' (3). Affairs had not improved much by 1874, when Henry Maudsley (a prominent psychiatrist) cheerfully suggested that maternal 'insanity' was a disorder of intellectual, studious women (4).

Today, the Marce society for perinatal mental health (established in 1981) collects and discusses current medical research in the field. At its roots sits the spirit of Channi Kumar. A Punjabi-born psychiatrist, and pioneer of the first Mother-and-Child unit in Maudsley Hospital, London, Kumar's reverence of the mother-child bond underpinned his essential 'human' perspective. (5).

He broached the important questions that embody and stir the field today; what is the effect of psychotropic medication on both the mother and the baby? How are such medications transmitted in breast milk? How can the doctor, in their treatment of the mother, ensure that the infant's interests are at the centre of all decision-making?

However, despite such a promising renaissance, it would take many more years (and unconscionable tragedy) to finally enact the full emergence of the specialty.

The breaking point

"I've been down this road before, don't want to breakdown or end up on psychiatric ward having ECT.

Got to keep going for her she's everything to me, more than life itself."

These were the desperate written thoughts of Daksha Emson, days before tragedy struck. On the 9th of October 2000, she stabbed and set alight both herself and her infant daughter, Freya. Freya died quickly of smoke inhalation, and Daksha of her burns 3 weeks later.

Daksha had suffered from bipolar disorder for a long time. She had painfully deteriorated, hidden away in her house, to the point of collapse.

She was a psychiatrist herself.

Of course, Daksha's case was somewhat unique; embodying the role of the unwell doctor forged a significant, deadly trajectory to her illness, as she feared non-confidentiality would 'haunt her work, life and treatment'. Still, her death

and the circumstances surrounding it were highly representative of a much bigger problem. As such, many lessons emerged through the formal enquiry (6) into her death. These lessons comprised both the risk factor profile of Daksha herself, and the broader landscape of perinatal mental health.

The recipe of 'risk factors' in psychiatry is highly specific to each individual patient, and Daksha was no different. She was a female, Indian, bipolar psychiatrist, who had suffered a previous serious overdose and was newly postpartum.

Further still, her relapse signature - the specific constellation of warning signs that serious illness was once again broiling on the horizon - was considered in the report. It included a lack of personal care, the insidious onset of winter months, and prodromal 3-4 weeks of 'poor concentration and difficulty sleeping'. A relapse signature is taken as a prompt for immediate treatment, requiring predictive foresight of the attending psychiatrist.

Due to a lack of specialist support, Daksha's signature was missed.

More broadly, the enquiry summarised the nature of perinatal mortality as follows:

1. Suicide is the leading cause of maternal death.
2. Most perinatal suicide is achived via more effective, violent means, rather than the more usual methods of female suicide (e.g., overdose).
3. The suicides often occurred in those socially advantaged.
4. Half of the deaths evaluated had a prior psychiatric history.

From these findings, policy change was urgently recommended:

1. **Specialist oversight -** All high-risk cases warrant specialist oversight by a perinatal psychiatrist, and the 'insidious' postcode lottery of access to specialist perinatal services must be abolished. Had Daksha lived in Hackney (rather than Newham), her 'chances of being alive today would have been much greater' as she would have been under a sub-specialist.
2. **Child-centred -** A 'child-centred approach' was promoted . This echoed the earlier, crucial sentiment of Channi Kumar - we must 'not forget the baby while we take care of the mother.'
3. **Inevitable relapse -** One of the key cornerstones of medicine is to prevent illness, as well as treat it. The report suggested that known sufferers of mental illness should be closely monitored with expectation of perinatal relapse.

Daksha's heavy footprints are sadly followed by many others. The Bristol suspension bridge saw the joint suicide-infanticide (2015) of Charlotte Bevan and her newborn infant, and maternal suicide is still a leading cause of death in the first postnatal year according to the maternal mental health alliance (7).

Who is the perinatal psychiatrist today?

Thus, the need for highly specialist doctors is clear.

This individual is a consultant psychiatrist who has completed additional training in perinatal mental health disorders. They diagnose, treat and support women suffering from perinatal blues, postnatal depression, birth-related PTSD and perinatal psychosis, and aid their reintegration into their community and (most importantly) their family. They aim to preserve the bond between mother and infant from its very formation.

Their daily schedule might involve outpatient clinics with follow-up both before and after birth, urgent assessments of acutely unwell women, inpatient unit management, and offering guidance to other doctors in the usage of psychotropic medications during pregnancy.

Research, too, forms a fundamental arrow to this professional's bow.

Both broad and highly niche research projects bring constant refinement to clinical practice. Channi Kumar, as the UK's first professor of perinatal psychiatry, set the stage with such areas of interest as cross-cultural variability in postnatal depression, mothers who struggle to bond with their babies, and the effect of postnatal depression on the baby themselve (8).

As a more recent example, perinatal psychosis has been studied extensively. Though its triggers are individually variable and multifactorial (9), some firm statistical risks are now known. At baseline, it affects around 1 in every 1000 mentally-healthy women, but this risk rises to 1 in 33 in women with a first-degree female previously affected (e.g., a sister or mother). Further risk, still, comes with a diagnosis of bipolar or schizoaffective disorder (1 in 5 for the first pregnancy), with a startling risk of 1 in 2 for women who've had an episode before. Therefore, a treating perinatal psychiatrist is both a doctor and a statistician - they must take a very careful medical history to stratify risk and implement protective measures alongside a patient's primary care physician in the pre-conception or early pregnancy stage if possible.

The timeline of when one can expect perinatal mental health events to occur has also been explored. It has been repeatedly shown that, for women experiencing psychosis, the period immediately following birth is far more likely to result in psychiatric relapse and admission than the prenatal period (10). This research is a great informant of clinical practice. It creates the ability to foresee potential ill-health and try to prevent (or prepare) for it.

Research into predictive outcomes for the infant is also crucial. It is known that particularly for perinatal depression and alcohol misuse, there is a significant risk of mental health disturbance for the child (11). Antenatal depression is also linked in many studies to childhood ADHD, behavioural conduct problems and Autism (12). Clearly, treatment of antenatal depression is crucial, but even this is not without issue; much like depression itself, prenatal antidepressant usage is associated with changes to the fetal serotonergic system and adrenal axis (13). Such a delicate balance is, again, difficult for the perinatal psychiatrist to navigate.

On a more specialist note, Psychiatrist Dr. Karyn Ayre was recently awarded the Daskha Emson prize for her seminal research into the epidemiology, trends and nature of self-harm in the perinatal period. Already a stigmatised behaviour, deliberate self-injury was found to be a rare but serious predictor of maternal and neonatal mortality. Such niche findings pave the way for improved opportunistic interventions with patients (for example, screening for a history or current pattern of self-injury).

The issue of mother-child attachment is also of key interest to a perinatal psychiatrist, both in clinical practice and in research. Though a complex interplay of genetics and maternal physiological factors contribute to infant mental health risk, a key predictor of poor outcomes is insecure maternal attachment style (14). Recognising this and offering support in the form of various therapies is crucial. Cognitive Behavioural Therapy, Maternal-Child-Interaction-Guidance and peer support are all examples which have shown promise in this area (15).

What challenges face doctors and patients alike in perinatal psychiatry?

Research difficulties are abundant in this field. In 1957, the anti-emetic thalidomide was launched to the European market. Pregnant women enjoyed immediate relief from morning sickness, anxiety and headaches, and it was hailed as a ‘wonder drug’. But then, in 1961, it was suddenly withdrawn from the UK.

It had caused untold misery.

Thalidomide (now known to be a fierce teratogen, or a substance that damages fetal development) led to devastating limb deformity or death in around 20,000 infants worldwide (16). And it is not alone; many medications (including psychotropic) are suspected or known to be harmful in the perinatal period (17). However, to study the effects of a psychotropic medication on a pregnant or breastfeeding mother is extremely difficult; who would be willing to risk the life or health of their baby for research?

In both clinical practice and research, perinatal psychiatrists must therefore make very complex decisions regarding which medications to continue, which to start, which to switch and which to stop. What are the mother's thoughts? How can this frightening but important information be shared with her, or even with loved ones who support her?

An example of one complex medication is lithium. This mood stabiliser is found to be 'lifesaving' for some women, yet risks Ebstein's anomaly (a cardiac malformation in the fetus) during the first trimester. How does a perinatal psychiatrist balance this risk in a woman whose mood disturbance is significant, and who can't imagine forgoing medication? Then again, some research suggests that lithium's risk may be overstated (18). Does one err on the side of caution? The dispensing psychiatrist faces an enormous task of continually evaluating the tide of incoming psychotropic research.

There is also the task of managing suicide risk. In the UK, the incidence of out-of-hospital suicide in the perinatal period is a leading cause of maternal death (19). The MBRACE UK society (which aims to reduce perinatal risk to mother and baby) has suggested areas where such risk is missed. Such examples include clinical misjudgement between what constitutes a 'normal perinatal anxiety' (e.g., 'I won't be good enough for my baby'), and what represents a dangerous thought pattern. The 'herald sign' of escalating symptoms was often missed. In addition, there existed a failure to accept patients who were of significant concern from their GP, but did not score 'highly enough' on standardised measures. This suggests the specialist expertise of a perinatal psychiatrist should always be available; rating scales alone cannot compromise full assessment.

There is also the issue of misattribution of physical symptoms as psychiatric. For women with known mental health conditions, the chest pain of a pulmonary embolism may be mistaken for anxiety, for example, leading to a serious failure of treatment (20). Thus, the perinatal psychiatrist must be able to distinguish keenly between physical and psychiatric aetiologies of different symptoms.

Another challenge for the perinatal psychiatrist is safeguarding (21). Indeed, in the words of Channi Kumar, a child's welfare is the centre of focus for both the mother and the psychiatrist, and to support a mother through mental ill-health is to support her infant (whether born or unborn). This is a complex area, as it involves both risk to the mother from others, or sometimes from the mother to her infant if she is unwell. Postnatal illicit drug and alcohol usage is one key risk to child safety, as are difficulties in physically caring for or attending to the infant's needs if mentally unwell. Additionally, dangerous domestic situations for the mother are by definition dangerous for the infant also (22). Importantly, safeguarding referrals should never be made simply on the basis that a mother has developed a psychiatric illness, but opportunities must also not be missed.

Missed appointments (whether psychiatric or obstetric) are often found to be a key warning sign that further support might be required.

The overall message from this body of work, and others like it, is that the psychiatric care of a woman at risk should be overseen by a perinatal specialist, and that the threshold for accessing services should be far lower.

To summarise, and to look forwards

Though great progress has been made so far in this exciting subset of psychiatry, pressing and urgent areas for improvement still remain. It is known that across many sectors of medicine, black and ethnic minority patients suffer poorer health outcomes in both developed and developing countries (23). Such inequality is apparent in the UK in both obstetrics (24) and psychiatry. For the latter, key issues include lack of access to services, and difficulties with trust and therapeutic alliance (25). Migrant women are also in a far more precarious position in the perinatal period than their native UK counterparts, due to uncertain legal status, lack of social support and unfamiliarity with the healthcare system (26). Finally, involuntary hospitalisation under the Mental Health Act is far more prevalent in black than white patients (27), as is being placed on a higher security ward and undergoing chemical restraint (28). Overall, there is a higher level of perinatal psychological morbidity for black and ethnic minority patients in the UK.

Though affecting a broad spectrum of psychiatric patients, these examples are keenly relevant to the field of perinatal psychiatry today. However, much promise in tackling these issues has been shown, with targeted interventions taking place across the UK (29). For example, the Merseyside Refuge and Asylum-Seeker's Pre and Post-natal support group, Liverpool, allowed its patrons to access peer support, social welfare assistance and help with depression and anxiety related to the pregnancy. Similarly, the Lad-Y-Lad (Hand-in-Hand) initiative in Manchester afforded specialist support to Jewish women experiencing postnatal depression. To pioneer or lead such enterprises within the UK is another exciting string to the bow of the perinatal psychiatrist.

Thus, what does a perinatal psychiatrist do? As explored, this doctor performs a highly complex, ever-evolving, yet fascinating job. Managing the most extreme of risks, liaising with other doctors and services, making complex pharmacological decisions are the backdrop to a delicate patient-doctor relationship. They hold the welfare of the mother and the infant in equal regard, yet constantly balance the benefits to one against the other. They walk right on the cutting edge of research, and sit on the busy intersection between obstetrics, mental health, race and inequality.

They are, overall, the greatest advocate of the bond between mother and infant.

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