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CAN-M: Camberwell Assessment of Need for Mothers

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2 The needs of women with mental health problems during pregnancy and the postnatal period

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Pregnancy is a time of physiological and emotional change for all women and these changes have particularly important consequences for women with enduring mental health problems. Psychiatric disorders are a leading cause of death during the perinatal period (pregnancy and up to 1 year post-partum) (Oates, 2000; Confidential Enquiry into Maternal and Child Health (CEMACH), 2004; Lewis, 2007). Women with chronic mental disorders who become pregnant are at high risk of obstetric complications with poorer outcomes for their babies, including low birth weight, intrauterine growth retardation, preterm birth, stillbirth and perinatal death (Bennedsen *et al*, 1999, 2001; Howard *et al*, 2003; Jablensky *et al*, 2005; Webb *et al*, 2005). This may be due to genetic susceptibility, poorer antenatal care or lifestyle factors (e.g. smoking, substance misuse, poor nutrition and socio-economic factors) (Howard, 2005). Psychotropic drugs may also have an effect on obstetric complications (in addition to the more common concern of teratogenicity), but no clinical controlled trials exist, with the few studies in the literature tending to be small with little information on confounders and drug dosage (Webb *et al*, 2004). There is some evidence that women with more common and less severe mental health problems, such as depression, tend to have shorter pregnancies and obstetric complications (Alder *et al*, 2007), though a recent meta-analysis examining anxiety symptoms during pregnancy and perinatal outcomes found no evidence of an association (Littleton *et al*, 2007); more research is needed to clarify the impact of depression and anxiety disorders on pregnancy. There is accumulating evidence though that severe psychological stress has an adverse effect on foetal development that is probably mediated through excessive stress hormone production in the mother. These stress hormones cross the placenta, inhibiting foetal growth and causing early delivery of the baby from an environment perceived as stressful. Severe psychological stress is now generally acknowledged as a common cause of preterm birth and/or low birth weight (O'Keane *et al*, 2006)

It is therefore clear that women with chronic mental health problems have specific obstetric treatment needs in addition to psychiatric treatment needs during the perinatal period. It is also well-recognised that mothers with SMI can have difficulties parenting, sometimes leading to loss of custody with mental health and emotional consequences of this for mothers and their families (Howard *et al*, 2003*b*; Howard *et al*, 2004). Many different health professionals come into contact with women with mental health problems during pregnancy and in the immediate post-partum period, providing many opportunities for intervention to prevent potentially serious sequelae. This chapter reviews the specific needs of women with mental health problems during pregnancy and in the early postnatal period.

Obstetric care in women with severe mental illness

Women with psychiatric disorders are less likely to receive adequate antenatal care than other women (Kelly *et al,* 1999). There is evidence from the USA that women with psychotic disorders book themselves in for antenatal care later than other women (Goodman & Emory, 1992), though this has

not been a consistent finding internationally (Howard *et al*, 2003*a*), and women with SMI may attend antenatal care less regularly than other women (Wrede *et al*, 1980; Miller & Finnerty, 1996). Yet these pregnancies are high-risk pregnancies which need optimal antenatal care. Patients with schizophrenia are at increased risk of impaired glucose tolerance and incident diabetes, particularly if they are taking atypical antipsychotic drugs (Kornegay *et al*, 2002; Lindemayer *et al*, 2003), and consequently at high risk of developing gestational diabetes. Women with chronic mental health problems are also more likely to be malnourished owing to self-neglect and/or substance misuse, and there is growing evidence that women with psychiatric disorders are more likely to smoke and misuse alcohol during pregnancy (Bennedsen *et al*, 1999; Howard *et al*, 2003*a*; Shah & Howard, 2006). However, general practitioners are less likely to record alcohol and smoking consumption during pregnancy in women with psychotic disorders (Howard *et al,* 2003*a*), suggesting that healthcare professionals may focus on the patient's psychiatric disorder to the neglect of important aspects of obstetric care. Antenatal care for women with psychotic disorders should therefore include support for women to reduce risk factors for poor perinatal outcome, including tobacco use, substance misuse, malnutrition and obesity.

Treatment needs are very complex during pregnancy and consideration about treatment when breastfeeding also needs to be taken into account at this time. Women with chronic psychiatric disorders and healthcare professionals may be concerned about possible adverse effects of prescribed drugs on the foetus during pregnancy and in the past many women have had their medication stopped during pregnancy for this reason. The pragmatic use of psychological interventions is altered by pregnancy and breastfeeding, in terms of availability, ease of access and the patient's capacity (increased physical demands and child care demands). However, not providing pharmacological or psychological treatment may produce more risks than benefits. In addition to behavioural disturbance which may put the mother and foetus at risk, it is possible that physiological changes associated with psychosis and affective disorders (e.g. increase in arousal, higher anxiety levels) could impact on the development of the foetus. Untreated psychiatric disorders may effect foeto–placental integrity and foetal central nervous system development (Cohen & Rosenbaum, 1998). It may therefore be necessary to change the type of treatment or change the treatment regimen to stabilise the mental state while avoiding foetal damage (see below). A collaborative review of illness history should include a risk–benefit assessment of treatment options.

A number of principles should guide the practice of clinicians treating women with psychotropic medication who are considering pregnancy, are pregnant or are in the postnatal period (National Institute for Health and Clinical Excellence (NICE), 2007). First, the individual women's views are key in decisions about treatment. A history of previous treatment response should be used to help guide treatment decisions and the lowest effective dose should be used if medication is thought to be necessary. Monotherapy should be used rather than combination treatments, and the balance of risks and benefits of pharmacological treatment may favour the prompt provision of psychological therapy instead. Changes in medication may be considered to reduce the risk of harm, but the risks should be balanced against the disadvantages of switching medication. Risks and benefits should be discussed with patients, partners and families in order to collaboratively agree on a care plan.

About 50% of women with a history of serious affective disorder, either recurrent depression or bipolar disorder, relapse during pregnancy (Viguera *et al*, 2000; Cohen *et al*, 2006). Findings from a study that followed about 200 women with recurrent depression through pregnancy have demonstrated that rates of relapse are 68% in those who discontinue medication following conception, compared with 26% in those who do not discontinue their mediation (Cohen *et al*, 2006). There is a general consensus that women at high risk of relapse of affective episodes (i.e. with a history of unipolar or bipolar disorder) should be particularly carefully counselled about the risks of discontinuing medication during pregnancy, although the balance of risks and benefits will vary and treatment plans should be individualised (Bonari *et al*, 2004; NICE, 2007).

Current evidence suggests that of the mood stabilisers available, lithium, while associated with a significantly increased risk of teratogenicity and, in particular, cardiac malformations, is a less harmful

choice is the safest choice during pregnancy. Antipsychotic medication has been recommended by NICE (2007) as a safer alternative. The risks and benefits of switching medication, the nature of the illness and the previous response to treatment should all be considered when considering the use of mood stabilisers in pregnancy. At present, NICE recommends that pregnant women should not generally be prescribed valproate, carbamazepine, lamotrigine or paroxetine, and patients who are breastfeeding should not be routinely prescribed lithium, lamotrigine, citalopram or fluoxetine (NICE, 2007). The evidence base for prescribing in pregnancy is limited and women need to be given up-to-date information on the risks and benefits of psychotropic medication during pregnancy.

With regard to women with schizophrenia, the evidence indicates that treatment with antipsychotic medication confers either no risk or a small non-specific risk for organ malformations (Diav-Citrian *et al*, 2005). The risks of relapse may be high for women with a diagnosis of schizophrenia who discontinue medication during pregnancy (Trixler *et al*, 2005), as are the rates of voluntary termination of pregnancies. The aim for the clinician should be to provide the best information available regarding the scope of possible risks associated with the treatment of schizophrenia during pregnancy. On the basis of the available data, generalisation is impossible and recommendations should be made on an individual basis. However, clozapine should not be routinely prescribed for women who are pregnant because of the theoretical risk of agranulocytosis in the foetus, or for women who are breastfeeding, as it reaches high levels in breast milk. Depot antipsychotics also should not be routinely prescribed to pregnant women because there is little information on their safety and the infants may show extrapyramidal symptoms several months after administration of the depot (NICE, 2007); however, pregnant women who have severe illnesses that have been treated effectively by a depot or clozapine with a high risk of relapse if the medication is changed will usually need to remain on their current medication. Some women with SMI may not be well enough to effectively weigh the risks of treatment with antipsychotic medication against the risks of illness exacerbation if untreated.

Women with severe mental health problems are at increased risk of domestic violence (Post *et al*, 1980; Cascardi *et al*, 1996; Dienemann *et al*, 2000) that may start or increase in severity during pregnancy (Gazmararian *et al* 1996; Bowen *et al*, 2005). Domestic violence during pregnancy is associated with considerable physical and psychological morbidiy, and a risk of death of the mother, foetus, or both, from trauma (Amaro *et al*, 1990; Pearlman *et al*, 1990; Martin *et al*, 1998; El Kady *et al*, 2005). The Department of Health recommends routine enquiry about domestic violence, but at present most women are not routinely asked about domestic violence during pregnancy (Clark *et al*, 2000; Foy *et al,* 2000, Renker & Tonkin, 2006). Many women need to be asked about violence several times before they feel sufficiently comfortable to discuss it and are more likely to disclose domestic violence to health professionals who are supportive, non-judgemental and who ask questions in a sensitive manner (Rodriguez *et al,* 1996; Bacchus *et al,* 2003). However, there is good evidence to suggest that very few women are angry, embarrassed or offended when asked about domestic violence (Renker & Tonkin, 2006).

Labour

There is a significantly increased risk of lack of detection of labour in women with schizophrenia compared with women with bipolar disorder (Spielvogel & Wile, 1992), which may contribute to obstetric complications in women who do not get appropriate help during labour. In women taking lithium, care needs to be taken to monitor and maintain hydration during labour as the changes in the mother's blood volume can lead to lithium toxicity in the mother and/or infant.

Perinatal deaths

There is evidence from a recent meta-analysis of a two-fold increased risk of stillbirth in women with psychotic disorders (Webb *et al*, 2005) and there is also evidence of an increased risk of neonatal deaths

(Howard *et al,* 2003*a*), particularly in women with affective disorders and substance misuse (Webb *et al*, 2006). This is likely to be due to lifestyle factors such as smoking and substance misuse, and may also reflect the poor condition of infants at birth of women with schizophrenia who tend to have a lower Apgar score (Bennedsen *et al*, 2001). Attempted suicide during pregnancy is also associated with neonatal and infant death (Gandhi *et al*, 2006).

Infanticide

A child under 1 year of age is four times more likely to be the victim of homicide than is a person of any other age (Marks & Kumar, 1993). Severe mental illness is directly implicated in only a minority of cases (Flynn et al, 2007), but there is an important association between fatal child maltreatment and parental psychotic disorder (d'Orban, 1979; Falkov, 1996). Less is known about more widespread but non-fatal harm or neglect of infants.

Psychiatric complications post-partum

Women with bipolar disorder have an approximately 23-fold higher risk of admission for a primary episode (Munk-Olsen *et al*, 2006) and increased risk for recurrent episodes in puerperal women, compared with non-post-partum and non-pregnant women (Terp & Mortensen, 1998). Post-partum psychosis is a clinical variant of an episode of bipolar disorder that occurs typically in the first few days following delivery of a baby and is characterised by confusion, perplexity, fleeting psychotic beliefs and false perceptions, typically auditory, visual and tactile. Mood tends to either be manic or mixed, i.e. rapidly changing from an elated to a depressed mood or elements of both mood states present concurrently (Pfulmann *et al*, 1998). Unlike other psychoses it develops very rapidly, over a few hours or a day at the most and if untreated can often result in suicide and neonaticide. It occurs in 50% of women with a history of bipolar disorder and in 70% with a further family history of post-partum psychosis (Jones & Craddock, 2001). Women presenting with this psychosis need to be assessed rapidly and treated aggressively with antipsychotic and mood-stabilising medication. There is a further increase in risk if there is a history of a post-partum mood episode after a first pregnancy (Freeman *et al*, 2002). Women with psychotic disorders may also be at increased risk of postnatal depression compared with controls (Howard *et al*, 2004). Postnatal psychiatric care should therefore focus on relapse prevention. The mother's mental state will need to be closely monitored so that a relapse of psychosis or affective disorder can be treated quickly.

Psychiatric disorders are a leading cause of maternal death in the first year post-partum (CEMACH, 2004; Lewis, 2007). Sixty-eight per cent of maternal suicides in the first year appear to be due to psychosis or severe depressive illness (Oates, 2000), although better management of acute post-partum illnesses may improve outcome (Oates, 2000). Post-partum psychosis often presents within the first few days post-partum (Heron *et al*, 2007) when a mother may still be on the obstetric ward; however, careful monitoring of the mental state is also needed when the woman goes home with her baby.

Parenting outcomes

Many women are able to rear a family successfully despite the presence of severe and enduring psychoses: motherhood can be a very important role for them (Krumm & Becker, 2006). However, psychotic disorders may make it hard for women to parent for a number of reasons: for example, antipsychotic medications that control symptoms may reduce responsiveness to children; withdrawal, delusional thinking and inappropriate behaviour when they occur can impair daily living and consistent parenting. Women with mental illness may also be less able to attend to their infant's physical needs

such as immunisation (Howard *et al*, 2003*a*). Even women with milder psychiatric disorders, such as mild to moderate depression, have difficulties forming emotional attachments with their children; these children are disadvantaged in terms of cognitive, behavioural and emotional development relative to their peers throughout their childhood.

Mothers admitted to a psychiatric perinatal unit are more likely to have significant parenting difficulties if they have a diagnosis of schizophrenia, belong to a low social class or have a partner with a psychiatric illness (Howard *et al*, 2003*b*). Social and illness factors are therefore clearly important in parenting. Neonatal complications are also associated with problems in practical baby care and perceived risk of harm to a child in women with psychosis (Howard *et al*, 2003*b*), though it should be noted that neonatal complications are associated with bonding problems in many parents (Feldman *et al*, 1999; Poehlmann & Fiese, 2001). Fear of custody loss is a central issue in the lives of these mothers (Krumm & Becker, 2006), and when custody loss occurs women understandably suffer considerable emotional distress (Dipple *et al*, 2002; Savvidou *et al*, 2003; Sands *et al*, 2004).

Health and social services are often asked to evaluate the parenting skills of women with psychotic disorders. In cases where there is strong concern about a pregnant woman's potential parenting skills, social services should be contacted for a prebirth case conference to plan parenting assessments post-partum. Parenting assessments can take place in the community, but if there is serious concern about potential risks to the baby, such assessments can be carried out on an in-patient perinatal unit (these units are available in some parts of the UK, France and other European countries, though there are few in the USA). However, at present, services do not always make assessments optimally – in a study of mothers in a psychiatric mother and baby unit in south London where there had been pre-birth concern, pre-birth planning, in the form of a case conference and arrangements for residential assessment, occurred in less than half of admissions (Seneviratne *et al*, 2001).

Postnatal care

Contraception

Women with psychotic disorders are less likely than controls to have a record of a discussion about contraception in the first year post-partum (Rudolph *et al*, 1990; Howard *et al,* 2003*a*), even though unplanned pregnancies are more common in women with SMI (Coverdale & Aruffo, 1989; Buist *et al,* 1990). Obstetric services, psychiatric services and primary care should ensure contraceptive advice is given to these vulnerable patients (if necessary, repeatedly), as a woman who is acutely psychotic may not be responsive to her own needs. Healthcare professionals caring for chronic mental health problems need to discuss contraception needs regularly throughout the childbearing years.

Conclusions

Many women with chronic mental health problems have children and their pregnancies are high-risk, with an increased incidence of obstetric and psychiatric complications. Pregnant women with psychoses are more likely to smoke and misuse substances than other childbearing women and they therefore need to be counselled on the risks to the baby, and given help to reduce their intake of these and other substances if possible. Optimal perinatal care frequently will also include psychotropic medication for women with chronic mental health problems, close monitoring of the patient's mental state, obstetric intervention to prevent obstetric complications, and psychiatric management of any psychiatric episodes during pregnancy and in the post-partum period. Health and social care needs of these vulnerable women should therefore be assessed regularly by healthcare professionals during pregnancy and post-partum.