

Mood disorders in pregnancy

How do they affect mother and baby?

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Many postpartum mood disorders can start during pregnancy and women with pre-existing psychiatric conditions can relapse during pregnancy. The risk-benefit ratio of treatment should be assessed to protect the mother and fetus.

The experience of pregnancy and motherhood is not the same for everyone and is rarely as it is portrayed by the media and on television – either as a blissful new life where women can have it all or a stressful time driving mothers to abandon their babies. The physical changes of pregnancy can be onerous and unexpected, and the financial and social implications can be difficult, particularly if the pregnancy was unplanned and/or unwanted. The whole concept of motherhood is influenced by the woman's age, social background, culture and early childhood experiences, and the presence of stress and mental illness have been associated with poorer obstetric outcomes.¹

The woman's current circumstances should be assessed by the GP as part of the management of pregnancy, as they are critical to determining her risk for developing mental health issues during the perinatal period; if she has a partner, he or she should be involved in this assessment.

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About 10% of women are likely to have significant depression and anxiety during this time (8.9% in the beyondblue study).²

Risk factors for antenatal mood disorders

Kendall's seminal paper in 1987 showed a 30-fold increase in psychiatric admission in the postpartum period compared with any other time in a woman's life, with a decrease antenatally possibly because treating professionals mistook psychological symptoms as being secondary to the pregnancy rather than being a mental health problem.³ At that time the focus of diagnosis and intervention for psychiatric problems by clinicians was during the first postpartum month, the time when postpartum psychosis occurred in one in 600 deliveries. However, since that article was published research and reviews have highlighted that women are at least as likely to be depressed during pregnancy as they are afterwards, with a personal or family history of affective disorders being key risk factors.^{4,5}

Women with pre-existing psychiatric conditions may cease their psychotropic medications when they discover they are pregnant, and this may in part lead to an increase in their symptoms antenatally.^{6,7}

KEY POINTS

- Mood disorders often begin in pregnancy, particularly during the third trimester.
- Women with mood disorders often present with anxiety symptoms focused on the pregnancy and unborn child.
- Women may mask their symptoms, afraid of the stigma of being seen as a bad mother.
- Stopping psychiatric medication, particularly abruptly, may not be in the best interest of the mother or fetus.
- The risk-benefit ratio of treatment must be considered for the mother and her unborn child, ensuring both parents are well-informed in order to make the best decision.
- Women with bipolar disorder or psychotic depression need referral to a psychiatrist.

This appears to be especially true in women with bipolar disorder and more severe illness who have not been euthymic for at least six-months before becoming pregnant. Recurrence of bipolar disorder has been shown to be twice as common in women with the condition who ceased mood stabilisers (86% vs 37%) compared with those who continued their medication; the average time to relapse was found to be two weeks in women who ceased treatment suddenly versus 22 weeks in those who ceased it gradually.⁸

Psychosocial factors need to be considered when assessing a woman's risks of antenatal depression and postpartum mood disorders (Box 1). The circumstances of the pregnancy will inevitably affect the woman's initial response to being pregnant: Was the pregnancy planned and is the baby wanted? What are her attitudes to the pregnancy and motherhood? What are her financial circumstances? What is the state of her relationship with the child's father?⁹ Does she have other supports? Useful questions to ask patients are listed in Box 2.

A poor relationship with her own mother and a history of abuse may underpin a woman's fear about her own ability to rear a child, as well as causing focused anxiety about childbirth. Enhancing



the woman is managing emotionally. Depending on the answer and the presence of risk factors, a further psychiatric history may be required. An enquiry should be made at each visit; screening early in the pregnancy and then again later is ideal.

Adjustment disorder

Pregnancy is a time of substantial physical change and mental preparation for the birth and caring of a dependent child. Many women who have unplanned pregnancies or fragile relationships with little support will struggle with aspects of these changes, if not during pregnancy then in the postpartum period. Women with a history of childhood abuse or a vulnerable personality are particularly at risk of developing an adjustment disorder, which may be associated with mood or anxiety.

If the woman has an adjustment disorder rather than major depression, her symptoms will fluctuate and she will still be able to function and enjoy aspects of her life. However, if the woman is struggling to talk and work through her issues surrounding the pregnancy, she will require careful monitoring during the postpartum period for the development of a more serious illness. In particular, women with a history of sexual abuse may need help addressing the anxiety around childbirth itself.

Major depression

As in the postpartum period, major depression during pregnancy may present as anxiety. 'Why would I be depressed, I want this baby' is a familiar misinterpretation of how women are feeling leading to a delay in seeking help and therefore a delay in diagnosis.¹¹ Often the woman's anxiety is focused on the pregnancy or the developing fetus. If her fears do not settle with reassurance and, where appropriate, negative test results, then the presence of depression should be considered. Psychosis should also be considered during pregnancy; however, if there is no previous history of psychosis, this diagnosis is more often seen postnatally.

Physical symptoms and the severity and

1. RISK FACTORS FOR ANTENATAL AND POSTPARTUM MOOD DISORDERS

- Family history of affective disorder, suicide attempts or alcohol abuse
- Past personal history of depression, anxiety, self-harm
- History of drug abuse
- History of domestic violence
- Poor support network
- Childhood abuse history
- Unwanted or unexpected pregnancy

2. USEFUL PHRASES AND QUESTIONS TO USE WITH PATIENTS

- It's common for women to be anxious in pregnancy. Are there things you are really worrying about?
- Stress is sometimes tough to deal with when you're pregnant. How are you going?
- I can see you really want to be a good mum. Asking for help can be one way of doing that (e.g. even though I know you like to be independent).
- I can understand you want to do the right thing by your baby, so let's think carefully about what's the biggest risk – the medication or you being unwell.

a woman's support network is likely to be a critical part of her management. Domestic violence and alcohol abuse patterns may worsen in pregnancy and may be orientated towards the abdomen. Women may feel even more trapped and unable to leave the relationship because of the tie through the child and the financial burden.¹⁰ Drug abuse, a risk factor for depression and parenting problems, will increase risks to both mother and child; if drug use occurs when the woman is responsible for the child, a risk assessment is required with possible mandatory reporting.

Diagnosis

There are three main mood disorders that require consideration during pregnancy, with anxiety disorders being the main differential diagnosis. Often anxiety and depression are interwoven and the main symptoms causing concern need to be established. Midwives and obstetric services may screen for these disorders and then request an evaluation by the GP. However, GPs who are managing or co-managing perinatal women should consider screening (e.g. with the Edinburgh Postnatal Depression Scale, which can be used antenatally, or the K10) and/or routinely asking how

persistence of psychiatric symptoms are the keys to differentiating major depression from an adjustment disorder. An adjustment disorder must occur within three months of delivery or other postpartum stressor and may have anxious and/or depressed mood but not fit the criteria of a major depression (Table).¹²

Sleep disturbance may be dismissed as being due to the pressure of the uterus on the bladder, reflux or the general discomfort of pregnancy but may be a symptom of major depression. A careful history of sleep separate from these issues should be taken. Fatigue can also be considered a 'normal' part of pregnancy but women should be asked if they are still getting enjoyment from their lives. A change in appetite can also be diagnostic – is the woman enjoying

TABLE. COMPARISON OF THE DSM-V DIAGNOSTIC CRITERIA FOR MAJOR DEPRESSION AND ADJUSTMENT DISORDER IN PREGNANT WOMEN¹²

Major depression in perinatal context	Adjustment disorder (anxious/depressed subtype)
<i>Five or more of the following symptoms lasting more than two weeks, which must include at least one of the first two symptoms:</i>	<i>Symptoms that cause distress and difficulties in functioning, occurring within three months of stressor and lasting less than six months and fulfilling the criteria for major depression (or anxiety disorder):</i>
Depressed mood	Sadness
Loss of interest (usually in everything, may be a little better with baby)	Loss of interest (but is interested sometimes in some things)
Significant weight changes (not explained by pregnancy and delivery)	No significant independent weight change
Sleep changes (not explained by discomfort of pregnancy or need to feed/settle an infant)	Sleep disturbance
Psychomotor agitation or retardation	Minimal psychomotor signs
Decreased energy out of proportion to other women at the same stage of pregnancy/level of sleep disturbance	Decreased energy
Feelings of worthlessness/guilt	Decreased concentration
Diminished concentration out of proportion to other women at the same stage of pregnancy/level of sleep disturbance	–
Thoughts of death/suicide – often persistent	Feeling overwhelmed, thoughts of suicide – usually fleeting

her food or just eating ‘for the baby’ or for comfort? Is she paying attention to her self-care? Any associated psychotic symptoms need to be regarded seriously and the woman should be referred for urgent assessment by a psychiatrist or crisis team if indicated by her level of risk.

Women with personality disorders and those who are drug abusing are particularly at risk of developing depression. This may be the one time that women will try hard to limit or cease their illicit drug and alcohol use, but as these substances often mask underlying problems, ceasing them may result in depression emerging.

Once the baby is born the woman may be assessed using the Edinburgh Postnatal Depression scale. If she has a score of 10 or more, a more detailed psychiatric history is warranted.¹³

Bipolar disorder

Women with known bipolar disorder are strongly advised to plan pregnancies and discuss their management with their psychiatrist. They should be closely monitored throughout pregnancy and the postpartum period. Women with these disorders require management by a psychiatrist.

Assessing risk–benefit ratio

Pregnancy is not a risk-free venture for anyone. Although worldwide maternal and child mortality rates have decreased dramatically in the past century, fertility, a normal delivery and a healthy baby cannot be guaranteed and suicide remains a leading cause of maternal mortality.¹⁴ Several risks exist that affect mother and fetus, including those listed below.

- Genetics may put the mother and/or

fetus at risk of a mood disorder.

- A current mood disorder in the mother is associated with less favourable obstetric outcomes independent of medication use.
- Being off medication might pose a risk of relapse to the mother, but being on it may pose a risk to the developing child.

In an ideal world, pregnant women would be well and not taking any medications or other drugs, with a good support system and access to psychological therapies if needed for prevention and treatment of mental illness. However, in the real world women have unplanned pregnancies or are in their late thirties or forties when they are planning pregnancies and do not have the luxury of time to become well and medication free. Psychotherapy is not suitable for everyone, even if they can afford and access it, and in those women with severe illnesses, medication and electroconvulsive therapy can be important forms of treatment.

Although there are large databases of information about the use of antidepressants in pregnant women and the outcomes, numerous confounding variables are present and no randomised controlled trials have been conducted in women who are pregnant. However, it is known that there is about double the rate of complications (i.e. fetal death, miscarriage and teratogenic effects) in pregnant women taking antidepressants compared with those who are not.¹⁵ Also, women taking antidepressants are more likely to be using multiple drugs or illicit drugs, drink alcohol (women taking antidepressants have been shown to have 10 times the rate of babies with fetal alcohol syndrome compared with women not taking them),¹⁶ smoke, be overweight and have diabetes – all of which impact negatively on the infant.

Studies have shown that pregnant women taking paroxetine have a higher rate of babies with heart defects, and babies of mothers taking fluoxetine while pregnant have higher rates of a range of problems such as respiratory distress at delivery.^{15,17,18} When considering which antidepressant

to start in pregnancy, if needed, sertraline is more appropriate if the woman wishes to breastfeed. The serotonin–noradrenaline reuptake inhibitors are secreted at slightly higher levels in breast milk than other antidepressants and may not be first choice unless indicated due to previous tolerance and efficacy issues.

Both depression and the use of antidepressants are linked to preterm birth.^{16,17} Discontinuation syndrome is common but short-lived.¹⁹ There may be a higher risk of developmental delays, but genetics and current mood disorder play a part here too, and a current disorder is likely to have an influence through attachment and parenting styles, and there may be compensation over time.¹⁷ A full review of these risks are available elsewhere¹⁷⁻¹⁹ and basic up-to-date patient information is available at www.ppmis.org.au.

If the woman's mood disorder is left untreated, there may be a risk to the fetus through the mother's decreased care of herself. In addition, infants of anxious mothers have high cortisol levels and maintain these throughout their life, which may represent an already altered and vulnerable stress response.^{20,21}

The best evidence to date suggests pregnant women with a mood disorder need to stay well, and if psychological therapies they are using do not work or are not suitable then they should be taking the minimum dose possible of as few as possible psychiatric medications. Overall, the average antidepressant doses used appear to be relatively safe to the fetus. Ceasing an antidepressant abruptly increases the risk of relapse, and for many women continuing to take medication may be the best option in the risk–benefit balance.

A multidisciplinary management plan for women with pre-existing mood disorders

Pregnancy in women with mental illness is a time for co-operation with the supporting family and between medical professionals across several specialties. GPs are at the forefront of day-to-day management,

with the back up of the obstetric, paediatric and psychiatric teams.

Management of pregnant women with mood disorders is a three-stage process.

- **Planning the pregnancy.** In an ideal world, the woman will be euthymic for at least a year with, in certain cases, medication withdrawn or reduced before becoming pregnant. Cognitive behavioural therapy (CBT) can be introduced at this time, either for the first time or as a refresher in women with depressive and anxiety disorders. Supportive and couple therapy focusing on adjusting and planning for the postpartum period is recommended. A meta-analysis of preventive strategies suggests a small but significant effect of several different therapies such as CBT, interpersonal therapy and medication.²² Recommended reading for the pregnant woman and her family include books such as *Overcoming the Baby Blues*²³ and, for those who cannot or do not wish to breastfeed, *Guilt-Free Bottle Feeding*,²⁴ and websites and brochures provided by the Black Dog Institute (www.blackdoginstitute.org.au) and *beyondblue* (www.beyondblue.org.au).
- **Implementation of an (ideally) pre-discussed management plan if the woman becomes psychologically unwell through pregnancy.** This needs to be individually tailored. Because of the risks of exposure to the fetus from medication, psychotherapeutic interventions are often preferred by the women, although there has been limited evaluation of their effectiveness in pregnancy. In cases of bipolar disorder or severe depression, medication and hospitalisation is likely to be required. GPs should consider referring the woman to a psychiatrist if her symptoms do not settle quickly or are severe and/or there are risk issues.
- **Planning the delivery and postpartum period.** Women on high doses of antidepressant medication ideally should deliver at a hospital with a neonatal

intensive care unit, and the baby will need assessment by a paediatrician.

The role of the GP throughout this period is to identify women with these disorders. GPs should have a high index of suspicion that women will mask symptoms, not associate the pregnancy with the mood changes or think their symptoms will improve afterwards. In addition, co-ordinating and ensuring ready and timely access to specialists is critical; GPs can often organise urgent appointments with specialists when their patients cannot.

Conclusion

Mood disorders are more common in pregnancy than previously thought. Early intervention can prevent a more serious postpartum illness and help smooth the transition to parenthood, improving outcomes for all family members. **MT**

References

A list of references is included in the website version (www.medicinetoday.com.au) and the iPad app version of this article.

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