Psychosis in the Perinatal period

RANZCP Webinar series for rural trainees and SIMG candidates
Tuesday 1 July 2014
WEBINAR OUTLINE

❖ Intro & Housekeeping

Dr Nicky Beamish, RANZCP Chair of the Special interest group in Perinatal and Infant Psychiatry Bi-National Committee

❖ Psychosis in the perinatal period

Prof Philip Boyce, Professor of Psychiatry and Head of the Perinatal Psychiatry Clinical Research Unit at Westmead Hospital.

❖ Exam content

Prof Anne Buist, Professor & Director of Women’s Mental Health at the University of Melbourne.

❖ Questions & answers

Participants (that’s you!) & presenters
HOUSEKEEPING

- The presenters can’t see or hear you, so if you are experiencing technical problems please telephone 1800 733 416 for IT assistance.

- If you are having trouble hearing the webinar through your computer speakers, you may dial in and listen via telephone.
  
  **Australia** - Dial 1800 896 323  
  **New Zealand** – Dial 0800 441 984  
  then enter the pass code 31995035#

- Use the chat box to ask for assistance
AUDIENCE PARTICIPATION

• Let us know who’s participating

• Send in your questions
Psychosis and the perinatal period

Philip Boyce
Sydney Medical School - Westmead Clinical School
philip.boyce@sydney.edu.au
### Disclosure

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<th>Activity</th>
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Overview

› General points
› Psychosis and pregnancy
› Schizophrenia, pregnancy and parenting
› Postpartum psychosis
› Bipolar disorder
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Treating perinatal psychosis
More than just symptoms

- Social support network
- Housing, Life-style, Diet
- Core psychotic Symptoms
- Medication, Health status
- Personality style, Attachment style
Schizophrenia and motherhood - Pregnancy outcomes

- High rates of poor pregnancy outcomes
  - Increased rates of:
    - Stillbirth\textsuperscript{1,2}
    - Neonatal death\textsuperscript{2}
    - Low birth weight\textsuperscript{1}
    - Preterm delivery\textsuperscript{1}
    - Small for Gestational Age\textsuperscript{1}
- Poor antenatal care
  - Stigmatised
  - Non-attendance
    - Poor health literacy
- Lifestyle
- Impact of high risk foetus
  - Neurodevelopmental theory of schizophrenia

\textsuperscript{1} Nilsson et al, 2002 \textsuperscript{2} Howard et al, 2003
### Adverse pregnancy outcomes in Bipolar Disorder

<table>
<thead>
<tr>
<th>Variable</th>
<th>Treated</th>
<th></th>
<th>Untreated</th>
<th>95% CI</th>
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<tr>
<td></td>
<td>OR</td>
<td>95% CI</td>
<td>OR</td>
<td>95% CI</td>
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<td>Gestational Diabetes</td>
<td>1.12</td>
<td>0.52-2.43</td>
<td>1.01</td>
<td>0.53-1.94</td>
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<tr>
<td>Instrumental Delivery</td>
<td>1.39</td>
<td>1.20-1.92</td>
<td>1.49</td>
<td>1.24-1.81</td>
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<tr>
<td>Caesarean Delivery</td>
<td>1.56</td>
<td>1.20-2.03</td>
<td>1.45</td>
<td>1.18-1.78</td>
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<tr>
<td>Preterm Birth</td>
<td>1.50</td>
<td>1.01-2.24</td>
<td>1.48</td>
<td>1.08-2.03</td>
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<tr>
<td>APGAR &lt;7 @ 5 minutes</td>
<td>0.88</td>
<td>0.33-2.34</td>
<td>1.56</td>
<td>0.85-2.86</td>
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(Bodén *et al*, 2012)
### Risks versus benefits of medication during pregnancy

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<thead>
<tr>
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<th>Taking medication</th>
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<td><strong>Benefits</strong></td>
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<tr>
<td><strong>Mother</strong></td>
<td>-</td>
<td></td>
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<tr>
<td>Foetus</td>
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<tr>
<td><strong>Benefits</strong></td>
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<tr>
<td><strong>Risks</strong></td>
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<tr>
<td><strong>Mother</strong></td>
<td>Persistent symptoms or relapse</td>
<td>Maternal wellbeing</td>
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<tr>
<td><strong>Foetus</strong></td>
<td>No risk of harm from medication exposure</td>
<td>Impact of illness on foetal development</td>
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<td>Risk of foetal exposure to medication</td>
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Illness episodes

FIGURE 1. Episode Occurrence Rates of Major Affective Episodes During Pregnancy and During the Postpartum Period in 1,162 Women With Bipolar I, Bipolar II, or Major Depressive Disorder

(Viguera et al, 2011)
Withdrawal of mood stabilizers

- Slow discontinuation at time of low stress
- Season when most stable
- Emphasize maintaining stable sleep/wake cycle
- Plan for contingencies
  - Early recognition of prodromal symptoms
    - Recruit significant other
    - ‘red card’ for danger symptoms
  - Prompt review of emergent symptoms
    - Strategies from CBT - cognitive restructuring (decatastrophizing), problem solving
    - Relationship therapy
  - Use of other medications to stabilize mood
Clinical management during pregnancy

› Pregnancy well being
  - Antenatal care
  - Parenting classes
  - Health literacy
  - Lifestyle/diet
› Psychoeducation
› Relapse prevention
› Medication adjustment
› Assertive treatment of emergent symptoms
  - Psychotherapeutic
  - Pharmacological
Characteristics of non-relapsers

› Stable and supportive relationship
› Asymptomatic for at least one year
› Good mental health literacy
› Planned pregnancy
› Relapse planning
  - Early warning signs
  - Action plan
  - Prompt access
› Social rhythms attended to - sleep
› Low dose antipsychotics for emergent symptoms/ sleep disturbance
Predictors of bipolar relapse

More severe illness
› Early age at onset ¹
› 4 or more episodes of illness ²
› Recent admission ³
› History mania/schizomania ³
› Psychiatric treatment in pregnancy ⁴

Prior postpartum episodes
› episode during first pregnancy ¹
› Prior postpartum relapse

Predictors of bipolar relapse

Pregnancy wellbeing
› Physical problems during pregnancy
› Anxiety or tension in pregnancy
› Excitement during pregnancy

Psychosocial factors
› Life stress
› Marital difficulties
› Young age

Lithium in pregnancy

› Regular monitoring
› Adjust dose to ensure therapeutic levels

Risk of neonatal lithium toxicity
  possibility of mother becoming dehydrated and toxic in labour
› 36 weeks gestation reduce dose by 60%
› Continue to monitor
› Return to full dose of lithium immediately postpartum

› Breast feeding not permitted.
Psychosis arising postpartum

1. Schizophrenia
Pathways to post partum psychosis

- No previous psychiatric history - well
- Asymptomatic bipolar disorder
- Symptomatic bipolar disorder
- Schizophrenia

Pregnancy

Post partum

Psychosis
Managing schizophrenia in the perinatal period

- Need to take a comprehensive approach to schizophrenia
  - Biopsychosocial approach
    - Social support – interpersonal relationships
    - Lifestyle
    - Diet
  - Need to go beyond symptom relief
    - Positive & negative symptoms, mood and cognitive symptoms

> Work with Child protection agencies
- Need to educate them about schizophrenia
- Good enough mothering
  - vs perfect mothering
Impact of positive symptoms of schizophrenia on parenting

Symptoms
- Delusions
- Hallucinations
- Disorder of thought form
  - Disorganised speech
- Disorganised behaviour

- Incorporation of infant in delusions
- Distracted by hallucinations
- Chaotic behaviour
  - Delusions/hallucinations
- Distractibility
  - due to perplexity
- Inattention
- Poor communication with infant
Impact of negative symptoms on maternal behaviour

Impoverished environment for the infant - poor quality interaction

› Disinterest - poor planning
  - anhedonia

› Lack of responsiveness
  - anhedonia

› Limited play
  - Avolition
  - Amotivation

› Limited talking with infant
High expressed emotion and new mothers with schizophrenia

- Societal pressure
- Child protection agencies
  - Worsening symptoms with excess scrutiny
  - Increased risk of removal
- Community teams
  - When lack knowledge in impact of criticism and relapse
- From infant - developmental stage
Neurocognitive deficits in schizophrenia

- Attention, concentration, & vigilance
- Memory
- Language skills
- Planning and executive function
Schizophrenia and motherhood

› Assertive clinical care that targets specific deficits
› Combination of:
  - Good psychopharmacology
    - Therapeutic effects vs adverse effects
  - Cognitive remediation
  - Psychosocial treatments
    - CBT
    - Social skills rehabilitation
  - Social interventions to address unmet needs
› Advocacy for the women
› Liaison with Child protection
Camberwell Assessment of Need for Mothers

Louise Howard, Katherine Hunt, Mike Slade, Veronica O'Keane, Trudi Seneviratne, Morven Leese, Graham Thornicroft & Malcolm Wiseman
Psychosis arising postpartum

2. Bipolar disorder
Onset of psychosis following childbirth

Edinburgh Data linkage studies

Relative risks of first readmission in relation to childbirth by diagnostic group

Days postpartum

- Bipolar disorder
- Schizophrenia like disorder
- Others

Fig. 1. Temporal relationship between psychiatric admission and childbirth: (a) all admissions; (b) psychosis admissions.
Puerperal psychosis

Onset within the first three weeks postpartum
Clínical Picture – nosological status uncertain

› Confusion/perplexity
› Psychotic symptoms
  - Delusions
    - Generally infant related
  - Hallucinations
  - Disordered thought form
› Mood symptoms
  - Depression (melancholic/delusional)
  - Mania
  - Mixed features
› Catatonic symptoms
Puerperal psychosis
Management

› Psychiatric emergency
  - Risk of harm to infant
  - Infanticide / Neonaticide

› Admission to a Mother-baby unit

› Treat underlying pathology
  - Antipsychotics – first generation
  - Antidepressants
  - Mood stabilizers
    - Breastfeeding contraindicated for lithium
  - Benzodiazepines for catatonic features

› ECT

› Support for partner

› Support for mother-infant relationship
1. Medication free
   - Careful planning
   - Discontinue medications pre-conception
   - Psychoeducation – early warning signs
     - Plan what to do for emergent symptoms
     - Prompt access for treatment
   - Regular review
   - Psychosocial treatment
     - Social rhythm therapy
     - Stress reduction
Planning for the postpartum period

› High risk of relapse for the first 3 weeks
› Anticipate stressors
  - Stress inoculation
    - Anticipatory problem solving
› Maintain stable social rhythms
  - Strategies for sleep
› Regular review
› Prompt access
2. Medication free – with lithium prophylaxis

- Introduce lithium mid 2\textsuperscript{nd} trimester
  - After scans are clear
  - Regular monitoring to ensure therapeutic dose
  - 36 weeks gestation, drop dose of lithium
    - Reduce risk of neonate developing lithium toxicity (floppy baby)
  - Return to therapeutic dose immediately postpartum
  - No breastfeeding

Regular contact with obstetric team and neonatologist

Involve partner
Thank you for your attention
SO YOU GOT A PERINATAL CASE BUT NEVER WORKED IN AN MBU?

Anne Buist
MD, FRANZCP
• Pregnancy: planned? Wanted? IVF or fertility issues? Physical complications?
• Labour: as planned (ie how planned…)? Traumatic?
• Early Attachment
• Managing babies needs (feed, sleep) vs own needs (sleep, needing to be perfect?/feelings of failure)
• Any awakening of Ghosts in the Nursery? – own attachment; was mother available/did she have depression?
• Relationship with partner and supports critical
KEY DIFFERENCES ON RISK ASSESSMENT

• Risk not just to self but to baby
• Includes active infanticidal/incorporation into delusions/hallucination and neglect/distraction because of:
  – illness
  – Poor parenting role model/attachment issues in own childhood
  – Organic factors such as drugs, alcohol and IQ
  – Side effects of meds
KEY DIFFERENCES IN FORMULATION

- Consider attachment to own mother as well as baby
- Role of pregnancy in this presentation
KEY DIFFERENCES IN MANAGEMENT

- DO NOT USE GENERIC PLAN!!!
- Risk to infant includes long term attachment issues
- Issues of meds in pregnancy and breastfeeding
- Contraception/future pregnancies
Thank you for your participation

Please complete the exit survey at the conclusion of the webinar

Continue the conversation on the new College online forums [www.ranzcp.org foraums](http://www.ranzcp.org/forums)
- Use your College membership details to login
- Agree to the Terms and Conditions
- Find our thread in the Clinical Practice issues section titled ‘Psychosis in the perinatal period’