Approach to Mental Health in the Peripartum Patient

Self-Study – Background for Classroom Discussion

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Learning Objectives

1. Be aware of common mental health presentations in the perinatal period
2. Understand risk factors for mental illness in the perinatal period
3. Develop an approach to mental health assessment in the perinatal period
4. Identify and screen for trauma in the peripartum patient, with an appreciation for complex trauma
5. Understand basic principles of Trauma Informed Care

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Mental Health in the Peripartum

Postpartum mental illness is the most common complication of childbirth

1 in 5 Canadian women

New presentation or relapse/exacerbation of existing mental illness

Most commonly, Depression and Anxiety Disorders, but also:

- Bipolar disorder
- Psychotic disorders
- Trauma and stressor-related disorders
- Obsessive compulsive disorder
- Eating disorders
- Substance use disorders

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Major Depressive Disorder

Criteria for the DSM-5 specifier "with peripartum onset":

> Current or most recent major depressive episode had onset during pregnancy or in the first 4 weeks postpartum

Note: Symptoms which overlap with "normal" pregnancy include fatigue, changes in appetite, poor sleep.

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Major Depressive Disorder

Up to 20% of all pregnancies are complicated by perinatal depression

Of these women, 20% will continue to have symptoms after the first year postpartum

And 13% will continue to have symptoms after the second year postpartum

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Anxiety Disorders

Reported **prevalence rates for anxiety disorders in pregnancy range from ~5%-40%,** depending on methodology and which disorders are considered (including specific phobias increases the rates)

- Roughly 10% of all women meet criteria for generalized anxiety disorder (GAD) in pregnancy

Many studies suggest that the prevalence of anxiety symptoms may be higher during pregnancy than in the postpartum period.

- Pregnancy may be associated with physiologic tachycardia, shortness of breath, nasal congestion, and other changes that can contribute to panic in individuals with heightened somatic sensitivity

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Anxiety Disorders

Perinatal anxiety is often comorbid with depressive symptoms. This comorbidity has been shown to manifest into more severe symptoms with poorer outcomes (both acute and long-term), is more difficult to treat, and increases the risk for suicide.

Insomnia is a frequent companion to anxiety and is associated with more severe illness and increased risk of psychiatric decompensation.

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Obsessive Compulsive Disorder

6.5% of first time mothers meet criteria for postpartum OCD, with many others experiencing subthreshold symptoms

- compared to lifetime prevalence of 2.3% for general OCD

Be aware of differences that may characterize peripartum OCD:

- Intrusive thoughts often about harm to child, caused by mother or otherwise
- Compulsions often checking compulsions to make sure infant is safe

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Bipolar Disorder

Women with Bipolar Disorder are in particular at very high risk for relapse in the postpartum period.

- One study (Viguera 2007) found that women who stop mood stabilizing medication have an 85% risk of recurrence in pregnancy and spent 40% of their pregnancy in an illness state.
- Among those who rapidly stopped their medication (1-14 days), 50% experienced a recurrence within 2 weeks. Those who discontinued medication gradually (>15 days), 50% relapsed after 22 weeks.
- Women who continue their mood stabilizers may relapse as well, albeit at a lower rate of 33% and spend less time in an illness episode (9% of pregnancy).

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Bipolar Disorder

While the **most common postpartum mood episode for women with Bipolar Disorder is depression**, there is also an increased risk of postpartum psychosis.

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Postpartum Psychosis

Very rare: from 0.25 to 0.6 per 1,000 births
(based on admission data from large population-based register studies)

The majority of PPP cases occur in the first **2 weeks** after birth.

PPP is often considered a Bipolar Spectrum Disorder, although there is thought to be a subset of patients who only have episodes in the context of the postpartum time-period.

PPP is associated with an increased risk for suicide and infanticide.

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Substance Use Disorders

Women with substance use disorders often present later to prenatal care, thus narrowing the window of time in which to assess and engage them in discussions about treatment.

Amongst women entering substance abuse treatment, pregnant women are most likely to identify marijuana as their primary problem substance, whereas non-pregnant women most commonly identify alcohol as their primary problem.

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Substance Use Disorders

Data from epidemiologic survey show that rates of past month use for all substances decreases among pregnant women as compared to reproductive aged women who are not pregnant.

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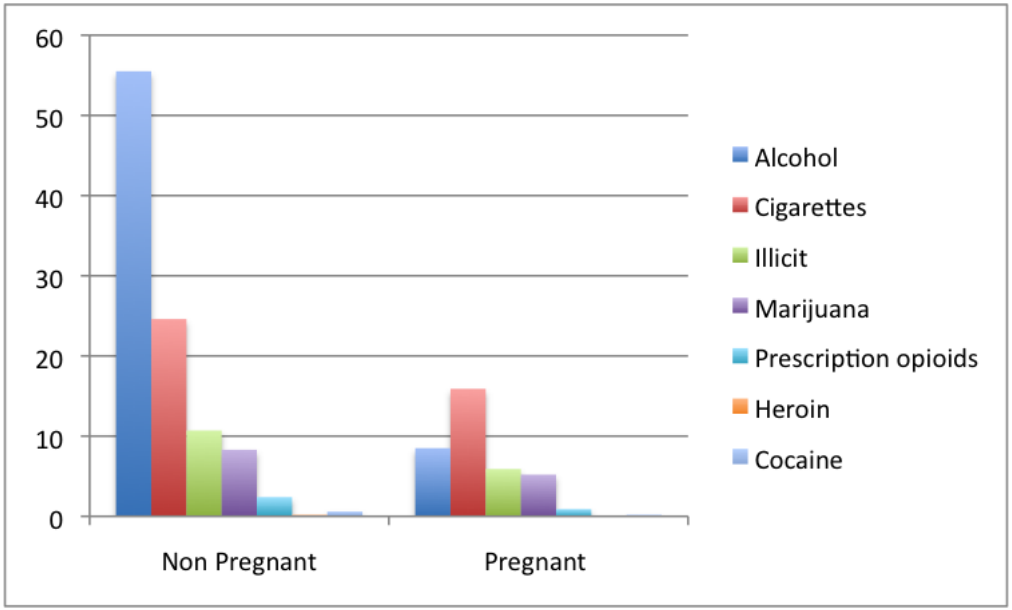
Pregnancy is a window of opportunity for the treatment of Substance Use Disorder in women



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Drug use in the past month, females 15-44

Substance Use Disorders

Women with severe SUD are at high risk for postpartum relapse, and this risk is highest in the 6-12 months postpartum

Women with SUD are at higher risk for postpartum/perinatal mood episodes and should be monitored at an early postpartum visit and frequently thereafter

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Trauma-related Disorders

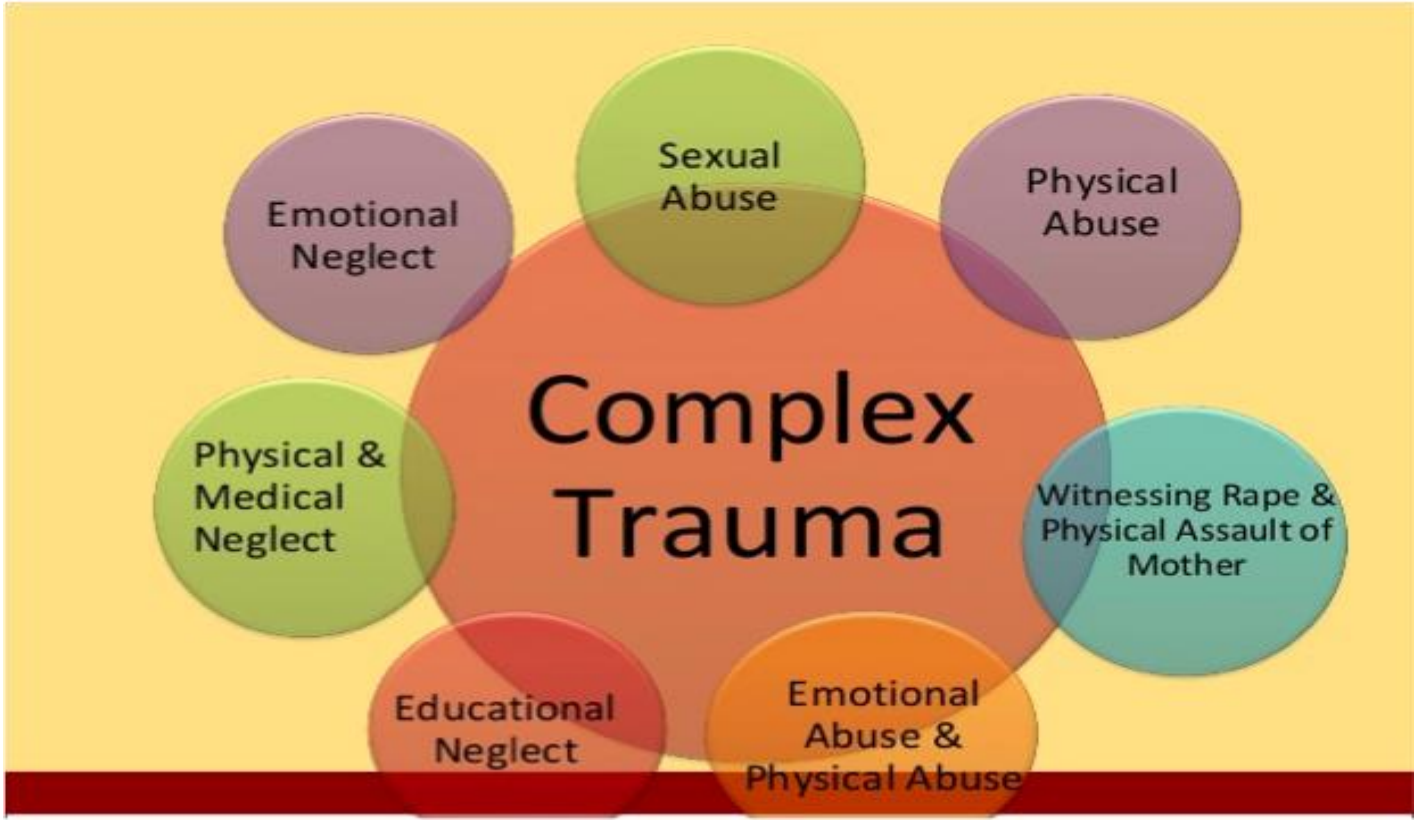

Image credit: http://www.slideshare.net/JaneGilgun/resilience-adult-attachment-in-cases-of-child-trauma/13

Burden of Trauma

- About half of all women in the US will be exposed to at least one traumatic event in their lifetime. (1)
- Research indicates that women are more vulnerable to sexual assault and childhood sexual abuse than men. (2)
- Per CDC National Intimate Partner and Sexual Violence Survey conducted in 2010 1 in 5 women (18.3%) in the US have been raped at some point in their lives. (3)

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Burden of Trauma

Birth Trauma

- As many as 1/3 of women rate their delivery as significantly distressing
- Significant minority met criteria for postpartum-PTSD (PP-PTSD) (acute PP-PTSD 4.6-6.3%)

Reproductive Loss and Posttraumatic Stress Disorder

- In USA, 16% of pregnancies end in spontaneous abortion (SAB) or stillbirth
- About 19% of pregnancies end in elective abortion (EAB)
- 12-32% of SABs and EABs can lead to PTSD (Hamana, 2010)

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Intimate Partner Violence

Major Domains of Intimate Partner Violence

- Physical: Hitting, slapping, punching, shoving, biting, use of weapons, choking
- Psychological/emotional: threats of violence, intimidation, humiliation, controlling behaviors, social isolation, stalking, forcing person to engage in illegal activities, forcing person to engage in substance use
- Sexual: forcing or coercing into any sex act the person does not want to participate in, sabotaging use of contraception, coercing pregnancy, intentionally infecting with STD

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Risk of PTSD

- Women are twice as likely as men to develop PTSD after a traumatic event and to carry this diagnosis across their lifetime (12% women vs. 6% men) (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995)
- Approximately 8% of women have PTSD in pregnancy or postpartum, and fewer (3%) develop new onset of PTSD after a traumatic childbirth (Ross & McLean, 2006)
- Finally, a history of childhood abuse also increases the risk of perinatal PTSD, in part, through a heightened likelihood of engaging in abusive or unsupportive relationships (Smith, Poschman, Cavaleri, Howell, & Yonkers, 2006)

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Dissociation

- DSM 5 includes dissociative subtype (complex PTSD) in its diagnostic criteria
- Can result from severe childhood maltreatment/sexual abuse
- Dissociation could increase risk for abuse/neglect of her children.

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Risk Factors for Peripartum Mental Illness

Insomnia is one of the most consistent risk factors for postpartum psychiatric decompensation and must be treated aggressively

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Risk Factors, Cont'd

Biological:

- Younger age
- Pre-morbid or co-occurring psychiatric disorder/substance use disorder
  - For postpartum, untreated/undertreated mental illness in pregnancy
- Treatment discontinuation
- Family/genetic vulnerability to psychiatric disorder
- History of early childhood adversity
- Medical complications in peripartum
- Primiparity
- Sleep deprivation
- Lack of adherence to prenatal vitamins (micronutrient deficiency)
- Hormonal vulnerability

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Risk Factors, Cont'd

Psychological:

- History of trauma/adversity
  - subjectively negative childbirth experience
  - Experience of harsh/neglectful parenting styles
  - Maladaptive parenting model
  - Insecure attachment
- Perceived stress, sense of loss of control
- Difficulty with affect regulation
- Conflictual relationship with partner

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Risk Factors, Cont'd

Social:

- single status
- lack of support from father of baby
- social isolation
- lack of education
- low SES
- Childcare stress
- Child who is ill
- Financial stress
- Immigration
- Partner mental health or substance abuse
- Intimate partner violence

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Risk Factors, Cont’d

…Or may present with no obvious risk factors.

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Assessment

- General Psychiatric Assessment
  - ID
  - CC
  - HPI
  - ROS
  - Safety
  - Past Psychiatric Hx
  - Family Psychiatric Hx
  - Past Medical Hx
  - Current Medications
  - Allergies
  - Social History
  - Past Personal History
  - Mental Status Exam

SCREEN FOR TRAUMA

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Assessment: Peripartum Pearls

Broad Questions:

- How was your pregnancy/labour & delivery/experience of breastfeeding?
- How did your experience differ from what you expected to happen?
- How did you feel about how you were treated during perinatal care?
- How well supported did you feel from hospital staff, family, and friends?
- Did you feel your life or your baby's life was in danger?

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Assessment: Peripartum Pearls

Screen for previous mental health issues/symptoms during times of hormonal vulnerability:

- Previous peripartum
- Previous premenstrual symptoms

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Assessment: Peripartum Pearls

Ask about interpersonal dilemmas common to the perinatal period, including:

- Interpersonal role disputes: conflicts with a significant other
- Role transition: change in life status
- Interpersonal deficits/coping skills: difficulty in coping with interpersonal conflicts; social/community supports
- Grief

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Assessment: Peripartum Pearls

Ask about common themes of anxiety:

- major concerns include: miscarriage, the baby's health, delivery, caring for the baby after discharge, other children, and social stressors such as finance.

- Anxiety disorders differ from normative pregnancy-related worry by virtue of their intensity, persistence, and negative impact on a woman's functioning.

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Assessment: Peripartum Pearls

Ask specifically about intrusive thoughts:

- Ask a mother if she is having intrusive or frightening thoughts/visions of harm befalling her baby
    - Explore further to determine if ego-dystonic, distressing, to differentiate from thoughts of harm to infant that may be associated with psychosis, for example
- Ask about associated symptoms/behaviours, as intrusive thoughts may be accompanied by excessive worry about the thoughts, hypervigilance, infant avoidance, and/or frequent reassurance seeking from family and medical providers

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Assessment: Peripartum Pearls

Ask about sleep – don't assume sleep disruption is only due to baby:

- "as well as can be expected" does not give you a clear enough sense of degree of sleep deprivation or causes of sleep disruption
- Inquire whether she is able to sleep when her baby is sleeping
- Inquire what is getting in the way of sleep – anxious rumination, compulsive checking…
- Get a sense of the numbers
    - How many hours of sleep? Longest stretch?
    - How interrupted? How long awake each time?

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Assessment: Peripartum Pearls

Ask about impact – get specific and concrete:

- How much time spent/lost?
- How is it getting in the way? (of pleasurable and purposeful activities? of being present? of allowing others to help?)

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Assessment: Peripartum Pearls

Know how to ask about presentations specific to postpartum:

- Postpartum Psychosis
  - Early symptoms may include insomnia, mood fluctuation, irritability
  - Notable for delirium-like appearance, may experience disorientation, confusion, derealization, depersonalization
  - Relatively **low incidence** of certain psychotic symptoms including thought insertion, withdrawal or broadcasting, passivity experiences, hallucinatory voices giving running commentary
  - May experience mood-incongruent delusions often focused on the newbor (such as delusion that baby is defective in some way, possessed or in dange
  - Disorganized, bizarre behaviors and obsessive thoughts regarding the newb are typical
  - Delusions of altruistic homicide (often with associated maternal suicide) to "save them both from a fate worse than death" may occur

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Assessment: Peripartum Pearls

Ask about history of adversity/trauma:

- Early childhood adversity/trauma
- Adulthood trauma
- Intimate partner violence
  - Physical, sexual, emotional/psychological, financial abuse
- Reproductive trauma
  - Any previous loss (miscarriage or termination) can be traumatic
  - Traumatic labour & delivery experience

- Remote / Recent / Ongoing – safety considerations

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Trauma Informed Care

- Organizational structure and treatment framework
- Involves understanding, recognizing, and responding to the effects of of trauma
- Emphasizes physical, psychological, and emotional safety for both consumers and providers
- Helps survivors rebuild a sense of control and empowerment.

http://www.traumainformedcareproject.org/

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Core Principles of TIC

- **Safety** – ensuring physical and emotional safety
- **Trustworthiness** – maintaining appropriate boundaries and making tasks clear
- **Choice** – prioritizing (staff) consumer choice and control (people want choices and options; for people who have had control taken away, having small choices makes a big difference)
- **Collaboration** – maximizing collaboration
- **Empowerment** – prioritizing (staff) consumer empowerment and skill-building

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Approach to Asking about IPV

- Establish rapport
- Provide safe environment
  - Consider approach if partner begins to attend appointments
- Normalization
- Assure confidentiality
  - Know medicolegal requirements of mandatory reporting
- Ask directly without interrogating
- Validate patient experience
  - Show empathy
- Provide education and support
  - Safety planning
- Offer resources

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Approach to Asking about IPV

- If she denies IPV
  - Make it clear you are concerned, but don't interrogate. Let her know you are always available to talk and she can call or make another appointment at any time.
  - Inquire again at the next visit. Get into the habit of asking patients on multiple occasions, as circumstances change and/or they may eventually feel comfortable disclosing.

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