MENTAL HEALTH

MATERNAL MENTAL HEALTH - MYTHS AND MISCONCEPTIONS

RCGP Clinical Fellow in perinatal mental health Dr Carrie Ladd looks at the truth behind many widely held views regarding maternal mental health

In the UK, the role of the GP in maternity care has significantly changed over the last two decades with current emphasis on midwifery-led care for the majority of women with uncomplicated pregnancies.¹ This has meant women have much less contact with their GP during the “perinatal” time (the period from conception to the first birthday of that child) with some multiparous women who self-refer to the midwife only seeing a GP once during this time – at the postnatal check.

This reduced amount of contact with the GP does not help with the significant problem of under diagnosis. Up to half of perinatal mental health problems go undiagnosed² despite being common, with up to 1 in 5 women affected at some time during their perinatal journey.¹

The consequences of untreated maternal mental illness are significant and can be long lasting, not just for the woman directly, but also for her partner and their child, and there is now some welcome momentum among policymakers and commissioners to invest in and improve services. By correcting common myths and misconceptions about maternal mental health, this article aims to give an update for GPs discussing the range of problems that women can experience during this time, the factors limiting better detection and diagnosis, and the latest evidence base for management.

Myth and misconception 1 – motherhood is easy, natural and instinctive

Together with other health care professionals, GPs have a crucial role to prepare women for the challenges of birth and transition to motherhood, as the experience of these is hugely important in the development of subsequent mental health problems.

There may be wide discrepancies between a woman’s preconceptions about how these life events will unfold and the actual reality. For example, a woman who had anticipated she would breastfeed with ease may find herself feeling disappointed, frustrated or guilty if she could not manage to do so, and these negative feelings may then cloud the experience of early motherhood and be a factor in the development of postnatal depression. At the same time as discussing preparation for the considerable physical challenges of labour and the subsequent sleep deprivation that is near universal for new parents, GPs should discuss the possibility of mental health problems with women early on in pregnancy. Lack of awareness of the significance of their symptoms amongst women has been cited as another reason why women may not disclose to their GP, so limiting the detection of identification of maternal mental health problems.⁴

Myth and misconception 2 – depression in women is always postnatal, never antenatal

Despite 45% of pregnancies being unintended, there is a general assumption made by the public – and too often by health professionals – that a positive pregnancy test is welcome news for a woman.³ This pressure of an expectation of happiness is compounded by the overwhelmingly positive portrayal of pregnancy in the media as a joyous time in a woman’s life, which then makes the idea of a pregnant woman suffering depression a contradictory concept that many resist consciously or subconsciously. Although figures on the exact prevalence of antenatal depression vary, it is not uncommon in pregnancy with one study suggesting up to 20% of women are affected.⁴ The symptoms reported are similar to that of depression at any other time of life, including low mood or persistent sadness, fatigue, loss of interests or pleasure, but as well women may report feeling overwhelmed and unable to cope with the demands of their pregnancy or repeatedly present to the GP with concerns about the baby development.
The consequences of untreated maternal mental illness are significant and can be long lasting

Myth and misconception 4 – high levels of anxiety amongst new mothers is normal

Some level of worry is expected for new parents, particularly first time, and it is sometimes difficult for GPs to normalise the challenges of parenthood and at the same time not miss the symptoms of a mental health problem. Follow up appointments in this situation are recommended to pick up those who may be developing anxiety at a level that warrants a diagnosis. Although general anxiety disorder is less common in the perinatal period compared to other times of a woman’s life, the prevalence of other anxiety disorders such as obsessive compulsive disorder is higher at 2% for pregnant and 2.5% for postnatal women compared to 1% in the general population. This diagnosis may be missed if women are not asked specifically about recurrent, repetitive or unusual behaviours such as frequent household cleaning or distressing intrusive thoughts or images such as “dropping the baby”. Intrusive thoughts are not uncommon, but are concerning for women and those who they disclose them too. It is imperative that GPs differentiate between those women who have recurrent catastrophising thought processes of “what if?” scenarios and the rare cases of women with psychotic thoughts and intent to harm her baby; in cases of uncertainty, specialist perinatal advice must be sought for clarification.

Another anxiety disorder that is underdiagnosed in the perinatal time is post traumatic stress disorder (PTSD), which affects 3% women going through childbirth. Risk factors include obstetric complications and lack of communication with HCPs during a traumatic birth process and it is important to correctly diagnose the condition as the treatment for PTSD is specific types of high intensity psychological therapies, such as trauma-focused cognitive behavioural therapy and eye movement desensitisation and reprocessing known as EMDR.

Myth and misconception 5 – postnatal psychosis is rarely a first presentation of psychiatric illness

Women in the perinatal time can be affected by the full range of mental health problems that may occur at any other time in their lives, including conditions, such as schizophrenia or eating disorders. Yet there are also conditions specific to this time, such as postnatal psychosis (PP).

PP is a potentially devastating condition in which a woman may rapidly develop psychotic symptoms with or without depression, in the puerperal or immediate postnatal period. It is important for GPs to be aware of the condition and ask women about thoughts of wanting to self-harm, dissociation or ambivalence towards the baby. These are all red flag symptoms. As well, any signs of paranoia, persecution or intent to harm their baby warrant immediate referral to specialist perinatal psychiatry services and possible admission to Mother and Baby Unit.

Half of women who develop PP have a psychiatric history previously (usually bipolar disorder), but this means half of cases are the first presentation of psychiatric illness. Although GPs may only see this every few years with the incidence being approximately 1:500 births, they need to be aware of the condition as same day referral to the psychiatry team (within 4 hours) is indicated because of the speed of onset, fluctuation and severity of symptoms.
Although the number of women in the UK who commit suicide during the perinatal period is low, and those who commit infanticide even lower, the media coverage of these cases is disproportionate and the stories retain their ability to shock the public and professionals alike.

Research has shown that even when women are experiencing mild to moderate symptoms of perinatal mental illness, they worry that disclosure of their symptoms to a GP/HCP will lead to social services being involved and separating them from their baby. It is paramount that GPs approach women with compassionate and sensitive questioning, acknowledging disclosure takes courage, that there are effective treatments available and separating mothers and their babies is a very rare occurrence.

Myth and misconception 6 – social services will be often be involved

Myth and misconception 7 – the negative impact of maternal mental illness is mostly for the woman

Maternal mental illness adversely affects all members of the family unit at whatever stage they occur during a woman’s life. However, the negative consequences are most significant and long lasting if they occur during the perinatal period and there has been some significant research published in recent years highlighting this. The economic burden has been estimated to cost the UK economy £8.1 billion for one year cohort of births in the UK and two-thirds of this is for the impact on the child with short and long-term problems. These effects include an increased risk of preterm delivery, a negative effect on the emotional and cognitive development of the child amongst others. However, in the absence of co-existing social adversity factors, such as domestic violence or substance misuse, and with an appropriate level of treatment, these effects may be mitigated and the effects on the child minimal.

Myth and misconception 8 – antidepressants are not advisable in pregnancy and breastfeeding

This is an important area to discuss as there is much misunderstanding among the public and health professionals – no antidepressant is licensed for use in pregnancy and breastfeeding, but that does not mean none can be used with caution. However, GPs should offer women a range of options for treatment and each prescribing decision must be tailored to the individual woman and what is considered an acceptable risk to some will not be to others. GPs need to consider a woman’s previous psychiatric history, response to medication, intention to breastfeed, the woman’s preferences and current severity of symptoms before suggesting a single drug regime with the lowest effective dose or alternative psychological therapies or both. Current general consensus is that although there are some small risks to the foetus from taking SSRIs in pregnancy, these are usually offset by the risks of untreated maternal mental health illness. However, the evidence base is constantly changing and GPs are recommended to access the following resources to help them support women to make an informed choice and specialist advice should be sought if unsure.

This is important to discuss with women of child-bearing age, at the time of prescribing and during monitoring, even before they are considering trying to conceive or at a specific pre-conception appointment. They also need advice early in pregnancy. Further information may be found from:

- UK Teratology Information Service (UKTIS) (professional directed) - http://www.uktis.org/
- Best Use of Medication in Pregnancy (BUMPS) (patient directed) - http://www.medicinesinpregnancy.org/UK
- Drugs in Lactation Advisory Service (UKDILAS) (professional directed) - http://www.ukmi.nhs.uk/activities/specialistServices/default.asp?pageRef=2

It is essential that women are advised to not stop any antidepressant suddenly as there may be risk of withdrawal symptoms or relapse.

It is relevant to mention here that other medications used for severe perinatal mental illness, such as antipsychotics, mood stabilisers or lithium, should be initiated and maintained under the care of specialist mental health secondary care and should not fall under the direct responsibility of GPs.
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The fragmentation of the extended primary care team in recent years is another factor identified as relevant in the low level of detection of maternal mental health problems, with health visitors rarely working from within GP surgeries any more. This has created barriers to effective communication and cohesive working, which can lead to presumptions and misunderstanding. GPs may miss a crucial opportunity to pick up mental illnesses by assuming health visitors have asked a woman about her mental health so not asking themselves. GPs may not be aware of the role health visitors have in supporting women to navigate self-help options, postnatal exercise classes, online CBT, mother and baby groups and online parenting support. Many health visitors can also offer support and low intensity psychological therapies in line with guidelines published by NICE in 2014 that suggested psychological therapies were first line treatment for all but the most severe depression.

Additionally, IAPT services can offer low intensity psychological interventions, although this recommendation is seriously limited by the significant geographical variability across the UK of specialist trained staff in these services.

Myth and misconception 9 – health visitors offer little more than screening for maternal mental health illness

Although the risk of recurrence of maternal mental health illness is higher than the risk for women not previously affected, it is not inevitable and NICE guidance highlights the importance of a thorough mental health risk assessment when a woman presents at booking. Those women with a personal history of serious mental health disorder or with a first degree relative affected should be identified and referred early to specialist perinatal mental health services. Those with a history of postnatal depression have around a 40% risk of subsequent illness whether postnatal or not and women with a history of PP have a 50% risk of becoming ill in subsequent pregnancies. However, increased monitoring support and early intervention can improve outcomes and GP play a pivotal role in identifying those at risk.

Myth and misconception 10 – It will always happen again

Reference


KEY LEARNING POINTS/PRACTICAL IMPLICATIONS FOR GPS:

- Although maternal mental health problems are common, they are underreported by women and underdiagnosed by GPs
- Women taking psychotropic medication need preconception advice to make informed decisions about their medication
- All women should be asked about their mental wellbeing at every contact with their GP
- Women should be offered a range of options for treatment and supported to make an informed decision about medication use on an individual case basis and appropriate resources consulted where necessary
- Mental health clinical and risk assessment and timely referral to specialist services should improve outcomes for women, their infants and families