South Australian Perinatal Practice Guidelines

Psychosis in pregnancy and postpartum

This guideline covers psychosis in pregnancy and postpartum with particular reference to bipolar mood disorder, schizophrenia and drug-induced psychosis

Introduction

- Psychotic conditions can occur at any time of an adult's life and are common in the child-bearing years
- Schizophrenia is a severe and generally enduring mental illness. The incidence is 1 % in the population. Women with this condition often find it difficult to make good long-term relationships, look after themselves well or lead healthy life styles. Smoking, other substance use, accommodation and finance problems are often co-associated
- Bipolar mood disorder (Type I with full mania or Type II with less florid manic symptoms) occurs in up to 4 % of the population. It is an episodic disturbance, characterised by psychotic episodes, generally first manic / hypomanic, (lasting up to 4 months) and then followed by a depression, usually of several months duration. Women can be quite well between episodes although are sometimes chronically troubled by symptoms. Mood stabilizers can control mood swings; however, there are problems with their use in the first trimester of pregnancy as most of them are teratogenic
- Puerperal psychosis is a psychotic illness occurring in the first 28 days after childbirth, generally believed to be an episode of bipolar mood disorder. The first presentation of this illness may be in the days following the birth, usually of a first child. Women will often present as floridly unwell, with irritability or elation, psychotic thinking including delusions, and agitated behaviour. Presentations of this sort should be regarded as a psychiatric emergency and mental health care sought wherever possible
- Drug-induced psychoses are increasingly common in our society, with incidence difficult to calculate as there is a strong association now between mental illness and substance use: substance abuse can cause mental illness and many people with mental illness use substances as self-medication or for other reasons including life-style and friendship groups

Pre-pregnancy counselling

- Antenatally, women with psychotic illnesses may seek advice about hereditability of their illness and also the use of medications in pregnancy and breastfeeding. Use of relevant medications is discussed below
- Women with schizophrenia may require antipsychotics in pregnancy even when the risks to their fetus of using medication are uncertain, although of course known substantial risks must be avoided. Clinical care of the woman's mental health is necessary for both her and her offspring's sake
- Clearly, substance abuse such as amphetamines, marijuana, nicotine and alcohol will be discouraged but often harm minimization rather than avoidance will be the only possible pathway
- Whilst puerperal psychoses are rare (1-2 / 1,000 live births) for those who have had a previous puerperal psychosis and probably for those with bipolar mood disorder, the risk of a recurrence postpartum is 30-50 %
- Conversations with the woman and her partner can focus on balancing the risks of the illness occurring if off medication, the risks of medication in pregnancy on the fetus and mother, and the heightened risks postpartum of a psychotic illness. A written agreed management plan, using relevant medications as discussed below should be provided to the woman, her partner, and all members of a treating team, including general practitioner, obstetrician, midwife and mental health staff

ISBN number: 978-1-74243-359-2
Endorsed by: SA Maternal & Neonatal Clinical Network
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Psychotic illness antenatally

- Good mental health care will generally follow a bio-psycho-socio-cultural framework, with attention to the overall life and lifestyle of the woman as well as symptomatic treatment of her symptoms with medication

Biological

- Encourage regular antenatal clinic visits
- Good general hygiene and nutrition
- Motivational interviewing to help minimize substance use

Pharmacological treatment

Antipsychotic medications:

- The newer (second generation) antipsychotics: olanzapine (Zyprexa®), risperidone (Risperdal®), quetiapine (Seroquel®), aripiprazole (Abilify®), ziprasidone (Zeldox®), and amisulpuride (Solian®) have all been introduced in the last decade and there is very limited data on their use in pregnancy. They may cause metabolic changes in a fetus producing large for gestational age infants (Einarson, Boskovic 2009), and are currently all classified as ADEC Category B3 (for further information, follow link to Chapter 150 Use of psychotropic medication during pregnancy and breastfeeding: A guide to guidelines)
- The older traditional antipsychotics are generally classified as ADEC Category C, and may be preferred because of the metabolic problems above
- Information is constantly being updated and can be obtained from the Pharmacy (Medicines and Drug Information Centre at Women's and Children's Hospital on 08 81617222 (Mon – Fri 9 – 5) , the Organisation of Teratology Information Specialists (www.otispregnancy.org), or at Motherisk (www.motherisk.org)

Mood stabilizers

- Mood stabilizers may be used in severe clinical conditions and include lithium, sodium valproate, carbamazepine and lamotrigine. The first three have significant rates of teratogenicity, and lamotrigine may increase the rate of oral clefts, (follow link to Epilepsy in pregnancy) therefore risk of fetal abnormality must be weighed against risk and severity of illness recurrence, and the possibility of using another medication at least during the first trimester e.g. an antipsychotic. Use in later pregnancy may also have detrimental fetal effects such as possible neurodevelopmental problems with sodium valproate. Current advice from the Medicines and Drug Information Centre at Women's and Children's Hospital on 08 81617222 or online sites as above is always appropriate

Benzodiazepines

- These are all listed as ADEC Category C drugs, and are sometimes used to calm significant psychotic agitation. As always, it is a risk-benefit decision, made in conjunction with the woman and her family, and minimizing dosage where possible; however sometimes the clinical situation demands the use of some tranquilisation. Day time sedation can be aided with lorazepam, in maximum doses of 1 mg tds, with temazepam 10 mg used at night

Non-pharmacological treatments: psycho-socio-cultural considerations

- Good management of all psychotic illness in pregnancy and postpartum will include:
  - Psychoeducation, with provision of both written and verbal information to the woman and her immediate family
  - Counselling support

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- Practical support for other children in the family
- Couple therapy if necessary

Postpartum considerations

- Psychotic illness may occur in a woman with a pre-existing diagnosis, or may occur de novo as with puerperal psychosis
- Suppression of lactation with bromocriptine (Parlodel®) has been linked with puerperal psychosis and other psychiatric disturbances. Care is required if a similar drug, cabergoline (Dostinex®) is used to lower prolactin levels
- In general, the level of symptoms will guide management in the acute phase, rather than precise diagnosis, although mood stabilizers as a main plank of treatment in bipolar mood disorder (puerperal psychosis) will also be given
- Safety / risk considerations for mother and infant can be paramount initially as some psychotic illnesses at this time are florid, with delusions producing unpredictable behaviours
- The highest risk time for occurrence / recurrence of a puerperal (postpartum) psychosis is in the 28 days postpartum, with symptoms generally appearing within days of birth and sometimes within hours. Thus, preventive measures including mood stabilizers, antipsychotics and benzodiazepines for sedation can be introduced immediately labour is concluded, and some women may prefer to take the (unknown) risks of medication in late pregnancy. Type of medication and doses will vary depending on the woman's previous response
- When symptoms have developed, for instance in a first and unexpected illness episode, the management plan should include:
  - Urgent mental health assessment, ensuring an appropriate understanding of and attention to safety issues for mother and infant particularly but also others in the immediate environment, and level of symptomatology
  - Metropolitan: phone ACIS on 131465 and rural phone Rural and Remote triage 1800 182 232
  - Admission to a specialized psychiatric facility, usually a mother-baby unit such as Helen Mayo House in South Australia (on 08 83031183) where possible is generally appropriate. It is very important to try and keep the mother and infant together to help establish good attachment relationships and breast feeding, wherever safety considerations permit this
  - Commencement of medication: as discussed above, mood stabilizers, antipsychotics and benzodiazepines may all be appropriate. A typical daily intake if the woman is not breastfeeding could be lithium (with blood level monitoring), perhaps supplemented by a second generation antipsychotic like Quetiapine 600 mg daily and lorazepam up to 1 mg four times a day when necessary. Choice of medication could be quite different, particularly if the woman is breastfeeding, when lithium is contraindicated (see below)
- Long term mental health follow up is likely to be appropriate
- A substantial package of care is generally necessary, which will include family and professional support from a wide range of practitioners, including Child and Family Health Services, at times Families SA regarding child protection matters, as well as help with mother's ongoing mental health (and possibly drug-related) problems

Medications

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- All medications have potential side effects for the mother when used longer term and their ongoing use must be reviewed regularly
- **Lithium** is an excellent mood stabilizer but is generally not recommended with breast feeding unless the mother is sufficiently well-organised and compliant to understand the necessity for regular monitoring, adequate fluid intake particularly in heat waves or at times of physical sickness, and infant monitoring for signs of lithium toxicity. Thus it is highly unlikely to be the treatment of choice in the initial phases if a mother is breastfeeding
- **Sodium valproate** use in breast feeding: see below
- **Second generation antipsychotic use in breastfeeding:** as with these drugs in pregnancy, compilation of the relatively small amount of published data shows that only small quantities of these medications pass through into breast milk and few infant effects have been noted. Nevertheless, safety cannot be guaranteed and families must be suitably informed.

Effects on infant

- Safety considerations may initially be paramount as infanticide or other harm can occur as the result of maternal delusions, particularly command hallucinations. Keeping the infant separate, or observed at all times when with mother may be necessary until safety can be assured
- While the mother remains acutely unwell, she may find complete care of her infant very difficult as for instance her concentration may make it difficult for her to feed her baby. Keeping breast feeding going may be manageable but can sometimes be difficult
- Provided the infant is kept safe and nutritional and emotional needs are met by the mother and others around, the long term outcomes for infants of mothers with bipolar mood disorder generally fall within the normal ranges so assurance can be given to the family
- Medications such as sodium valproate do pass through in breast milk and have been known to cause liver dysfunction so some experts advise haematological monitoring

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Useful web sites

Children of Parents with a Mental Illness (COPMI). Available from URL: http://www.copmi.net.au/

Mental Health and Well-being. Available from URL: http://www.mentalhealth.gov.au

Multicultural Mental Health Australia. Available from URL: http://www.mmha.org.au

SANE Australia. Available from URL: http://www.sane.org

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Abbreviations

ACIS	Acute crisis intervention service
ADEC	Australian drug evaluation committee
COPMI	Children of parents with a mental illness
e.g.	For example
et al.	And others
mg	Milligram/s
OTIS	Organisation of Teratology Information Specialists
tds	Three times a day

Version control and change history

PDS reference: OCE use only

Version	Date from	Date to	Amendment
1.0	30 Nov 09	25 Jan 10	Original version
2.0	25 Jan 10	20 Apr 10	Reviewed
3.0	20 Apr 10	04 Sept 12	Reviewed
4.0	04 Sept 12	current	

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