THE PANORAMA OF PERINATAL MENTAL HEALTH

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What I will (attempt to) cover

1. PERINATAL MENTAL HEALTH ACROSS TIME

2. PERINATAL MENTAL HEALTH ACROSS PEOPLE – ALL THE “PLAYERS”: MOTHER, FATHER, BABY, TODDLER, GRANDPARENTS

3. PERINATAL MENTAL HEALTH ACROSS DIAGNOSES

PERINATAL MENTAL HEALTH DIFFICULTIES ACROSS TIME FRAMES

PRECONCEPTION

ANTENATAL

INTRAPARTUM and IMMEDIATE POSTPARTUM

POSTNATAL – UP TO THE AGE OF ONE

OR TWO (FIRST 1000 DAYS)

AND NOW INTRODUCING…FIVE (FIRST 2000 DAYS)

FOR ME: BACK TO THE FIRST 700

PRECONCEPTION

- OPTIMISING PRE-CONCEPTION HEALTH (LANG ET AL) – IPRIMARY PREVENTION/PUBLIC HEALTH MEASURES:
  - HEALTHY DIET/WEIGHT/EXERCISE
  - STOP SMOKING
  - ALCOHOL AND DRUG USE LOWER
- MEDICATION ISSUES – SPECIFICALLY ANTI-PSYCHOTICS – GET TO NORMAL WEIGHT! (C BREADON/PROF JAYASHRI KULKARNI NRAMP)

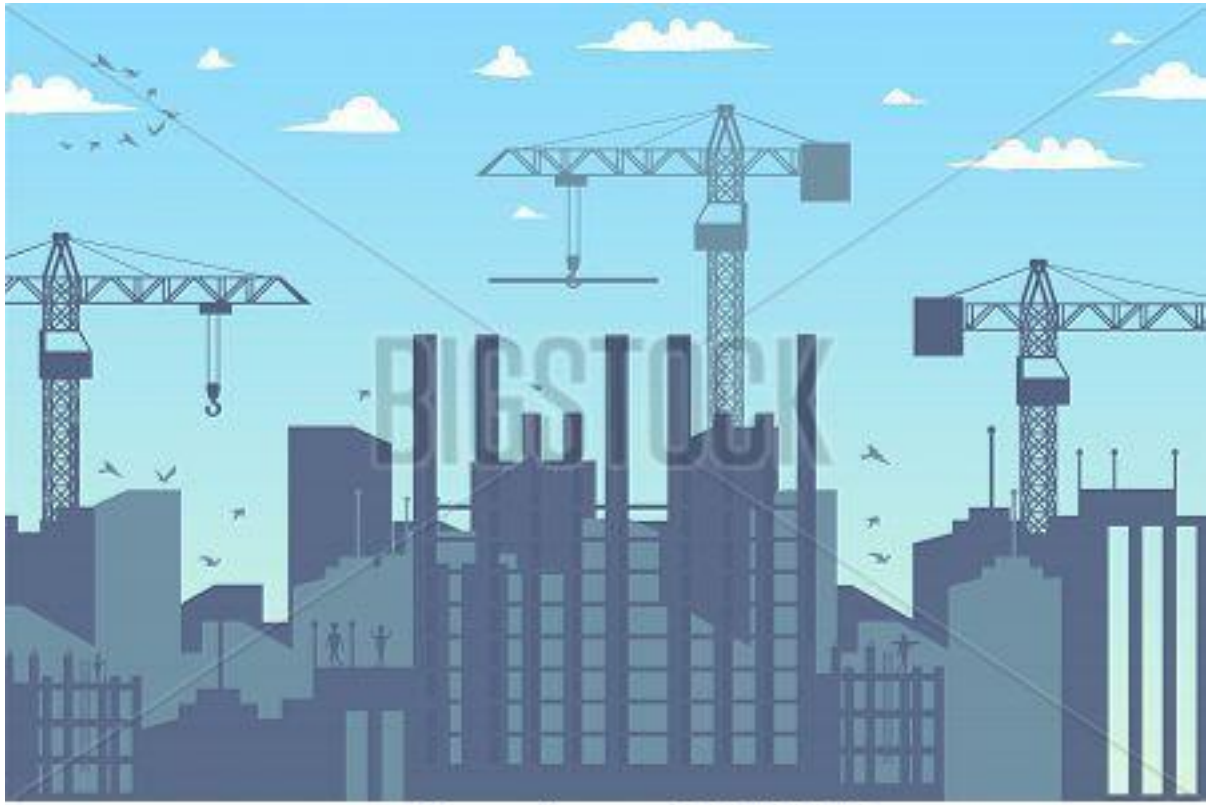
Antenatal mental health: the new big ticket items

EATING DISORDERS IN PREGNANCY – PROF MEGAN GALBALLY

SCREENING: GOOD TO DO IF YOU HAVE A PATHWAY FOR REFERRAL. EPDS, ANRQ/PNRQ. ???NOW…BPD

THE GUT AND MENTAL HEALTH:

TREATMENT OF IDENTIFIED PROBLEMS



MORE ABOUT BPD SCREENING!

- ALEX MAY: PhD student
- WE ARE TRYING TO GET HER STUDY THROUGH ETHICS
- SCREEN FOR BPD AND THEN??

INFANT GUTS AND THE MICROBIOME

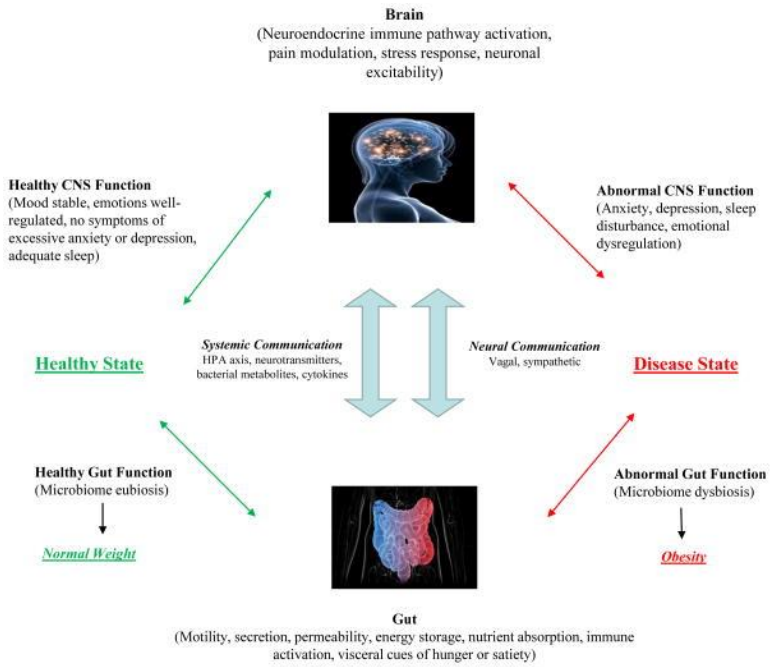
GUT BIOME : GUT WITH ITS BACTERIA + ORGANISMS

KEEP A HEALTHY GUT BIOME: HIGH FIBRE DIET AND PROBIOTICS EG YOGHURT

DELIVERING VAGINALLY HELPS INFANT DEVELOP A HEALTHY BIOME OF ITS OWN!

HEALTHY MATERNAL DIET IN PREGNANCY HELPS INFANT BRAIN AS WELL AS MATERNAL MENTAL HEALTH

BUT CHOCOLATE TASTES AWFULLY NICE….



MANAGEMENT OF ANTENATAL MENTAL HEALTH DIFFICULTIES

- BASICALLY THE MOOD DISORDERS: ANXIETY, DEPRESSION, ALSO EATING DISORDERS, OCD

- PSYCHOTIC DISORDERS: USE OF ANTIPSYCHOTICS

Treatment of perinatal depression and anxiety

Always part of a bio-psycho-socio-cultural framework for understanding the development of problems and then the interventions

Bio – the biological – physical health, genes, severity → medication?

Psychological – losses, trauma, grief, self-esteem, past parenting experiences

Social – all the relationships, present and absent

Cultural – very important!

AT THE MORE SEVERE END: MAKING A BIRTH PLAN INVOLVING ALL RELEVANT PEOPLE

Reviews of
treatment of perinatal depression, anxiety, trauma-related problems

-**Cognitive behavior therapy**
-**interpersonal psychotherapy**
-**Exercise**

-- **?Yoga**

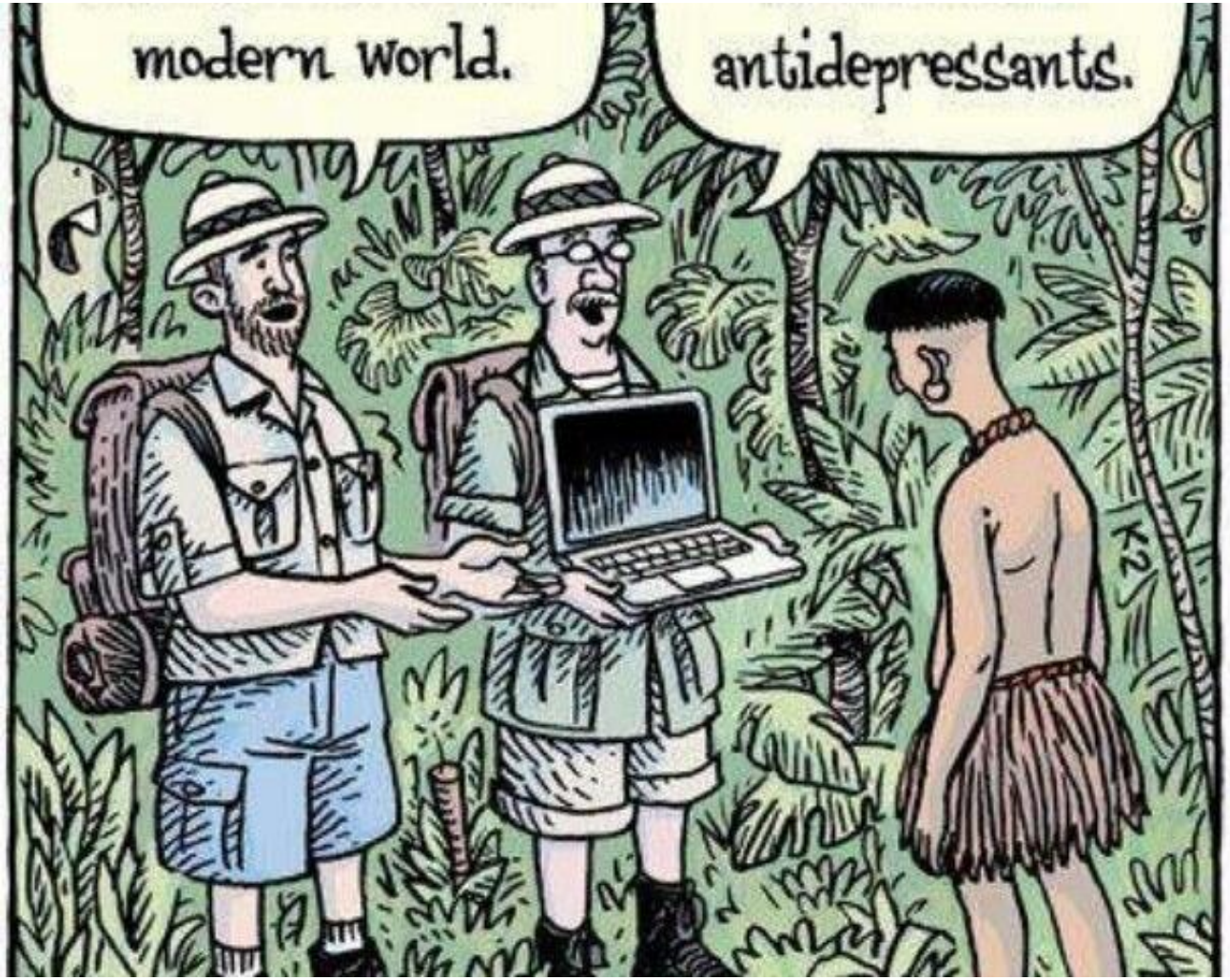
-**And then … medication**
-**Nilni et al**

And the newest cab off the rank…

INTERNET BASED INTERVENTIONS

Loughnan et al, MUMentum POSTNATAL – 3 session unguided iCBT for postnatal anxiety and/or depression was significantly helpful to women both in their mood and their management of their infants Improvements sustained at follow-up

EARLY DAYS YET BUT IT IS THE DIRECTION FOR THE FUTURE



Medications in pregnancy and breast feeding

- Risk-benefit analysis
- Never the first go-to
- No clear answers
- WE ARE NO LONGER GOD: WOMEN WILL MAKE UP THEIR OWN MINDS

" You play the nurse and I'll play God. "

The medication groups 1. Antidepressants

- Small indications of teratogenicity eg craniosynostosis, omphalocele
- Cause small babies which deliver early
- So does chronic stress/depression… (Jarde et al, JAMA 2016)
- Some withdrawal effects which show no evidence of long-term harm

- Other questions about antidepressants – eg efficacy
- But we all use them!
- And for breast-feeding – has usually considered to be very safe as only tiny quantities on weight basis in breast milk but recently a small question mark

Antipsychotics

- MAIN RISK
- weight gain, especially pre-conception. ?NOT TERATOGENIC
- Big babies, instrumental delivery, GDM, infant withdrawals, SBU/NICU admissions so deliver at big hospitals w neonatal special - STORY UNKNOWN STILL
- BREAST-FEEDING – little in the way of IDENTIFIED problems – ?? long term metabolic problems. ARIPIPRAZOLE CAN INTERFERE WITH BREAST-FEEDING

NB: MOTHERS WITH SCHIZOPHRENIA: MANY INFANT PROBLEMS EG SMALL PREM BABIES WITH ABNORMALITIES - ??? RELATED TO SMOKING

Mood stabilisers: the most vexed area

- **Lithium** – cardiac defects in first trimester: Thereafter safe for foetus AS BEST WE KNOW. Many issues with breast-feeding. Most effective at mood stabilization by a country mile
- Valproate – **NEVER USE**

18% abnormality rate and also ongoing IQ diminution – we avoid in all women of child-bearing age.

- Carbamazepine – not quite as bad – much the same
- Lamotrigine probably safest of these anti-epileptics

Keeping up to date with the information

- Pharmacy departments of maternity hospitals
- MothertoBaby.org
- UptoDate
- eTherapeutic Guidelines

Intrapartum and early postnatal

- Within birth care
- This is where PTSD starts…

- ***BIRTH TRAUMA***

Effects of delivery (and early postnatal)

- Physical tears often with ongoing consequences eg for sex life etc
- C-Section “I am a failure at everything and now can’t birth normally”
- Re-evoking of memories of past sexual traumas
- Birth trauma - for many reasons related to perceptions of care received, infant problems including deformity, prematurity, stillbirth, lack of choice at delivery, early failure of breastfeeding etc, and ?underlying difficulties

EARLY POSTPARTUM: PATRICIA O'ROURKE'S MATERNAL LOOKING GUIDE

- COMFORTABLE
- UNCOMFORTABLE
- WORRISOME

The range of psychiatric problems: (Old style: MAINLY POSTNATAL)

- The blues
- Puerperal psychosis
- Postnatal depression
- Postnatal anxiety
- (Drug and alcohol problems)

- **BUT NOW! DISORDERS OF EMOTIONAL REGULATION: BORDERLINE PERSONALITY DISORDER AKA…**
- **cPTSD (COMPLEX PTSD), ??ADHD**

The blues

- Incidence – 50-70% of all births
- Cause – hormonal change at delivery
- Time course – usually days 2-4 – maximum day 3
- Should be all gone by 14 days
- Treatment – recognition, affirmation, TLC

Puerperal psychosis: BPAD: BIOLOGICAL

- 1-2/1000 live births
- Present (allegedly) within 28 days
- Acute psychosis – with hallucinations, delusions, thought disorder, sometimes confusION
- Can be extremely sick sometimes for extended periods
- Can be extremely dangerous to self and infant
- **EXCELLENT PROPHYLAXIS** for those who have had it before with whom there is a 1 in 2 or 3 chance of recurrence

Postnatal depression

- The public face of all perinatal mental illness
- Incidence : 15%
- Symptoms – the whole panorama of depression
- But of course having a baby makes many complexities for the mother
- And for the baby (more later)
- And for (and from) the partner

WHY 15%?

- Parenting competence – under threat
- Grief for losses: freedom, independence, social network, etc
- Partner related – changing family dynamics as he deals with his changes – increased expectations on Modern Man and much less known about how to help him (including coming from himself)
- The BABY! THE TRIGGERS THEY UNWITTINGLY BRING

POSTNATAL MENTAL HEALTH SERVICES For PNAD

- Wow, where do we start?
- CAFHS and the For When coordinator
- Sonder and LTW AND NOW LIVESLIVEDWELL
- PANDA (phone support)
- Gidget Foundation (psychology support) AND SOON GIDGET HOUSE
- Mental health services
- Multiple others

P list: Prevention

- ◆ **Permission to drop Perfectionism: Good Enough = Goal!**
- ◆ **Personal Support (partner, {parents}, pals)**
- ◆ **Paid support eg cleaning, supermarket etc**
- ◆ **Professional support – GP, CYH, Women's groups, PND groups, PANDA**
- ◆ **Pills**
- ◆ **Psychotherapy**
- ◆ **Physical Phitness**
- ◆ **PC – online psychoeducation**
- ◆ **Prayer – {??support of church group}**

Other useful ways of staying in touch/getting information

- COPE on cope.org.au
- Joining Marce Society for perinatal mental health – marcesociety.com.au
- Harvard Center for the Developing Child, including YouTube clips on Serve and Return
- CERTIFICATES OF PERINATAL AND INFANT MENTAL HEALTH THROUGH HELEN MAYO HOUSE

Systems/couples work in PND: Cluxton-Keller et al

- FEW STUDIES
- BUT IT WORKS! COUPLE DIFFICULTIES ARE OFTEN A SIGNIFICANT PART OF PND
- MEN WANT TO DO THE RIGHT THING
- WHERE DOES SEX FIT IN?

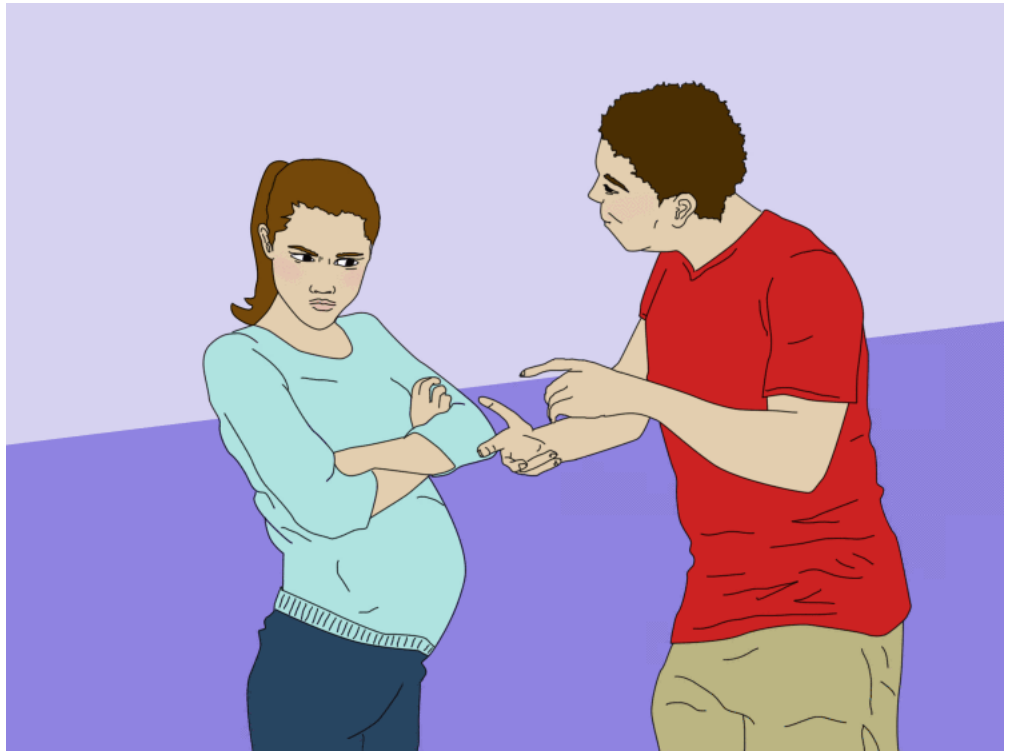
"Yes, I remember the last time we had intimate physical contact. We were arm wrestling for the last slice of pizza."

FATHERS

An increasing literature on fathers and their place in a family's life

- GOOD: Men want to help and many do a great deal of direct parenting and sharing of general chores
- GOOD: Men's mental health much more in the open and services beginning to appear eg
- SMS4Dads (Richard Fletcher) sms4dads.com

Family life is STRESSFUL



- ASK ABOUT DV!
- 36% women DV
- 22% in pregnancy
- ¼ of those for first time when pregnant
- EFFECTS ON CHILDREN OF FAMILY DV CAN BE LIFE LONG – HENCE CHILD PROTECTION TERRITORY

What do we do about domestic violence

1. IDENTIFY
2. DESPAIR
3. MULTIPLE SERVICES
4. MORE APPEARING
5. NOT THAT SIMPLE…. Average number of times a woman goes back to a DV relationship is…
6. Eleven

GRANDPARENTING!…

- Guess what characteristics do NOT work for grandparents?

- **CRITICAL**
- **INTRUSIVE**

So translating the words about grandparenting…

- So always be the “opposite”: Validating, available

- “Good-enough” grandparenting
- CULTURAL NORMS AROUND GRANDPARENTING

And the infant: A quick assessment tool: FEVAR (Matthey and Guedeney)

- Facial expression
- Eye Gaze
- Vocalisation
- Activity
- Relationship to examiner

- Score 0 for no concern, 1 for uncertain, 2 for definite problem
- If score 2+/10, take some action eg reassess at another time, ask CAFHS, paediatrician, infant mental health etc

What are the effects of maternal mental illness on infants

- VERY NON-SPECIFIC
- CUMULATIVE – PARENTAL MENTAL ILLNESS, PSYCHOSOCIAL CIRCUMSTANCES WHERE POVERTY HAS AN ENORMOUS IMPACT
- CONTRACEPTION IS THE ***BEST*** INTERVENTION BUT…BEWARE THE HORMONAL EFFECTS

Looking the other way around: Why does the baby affect the mother?

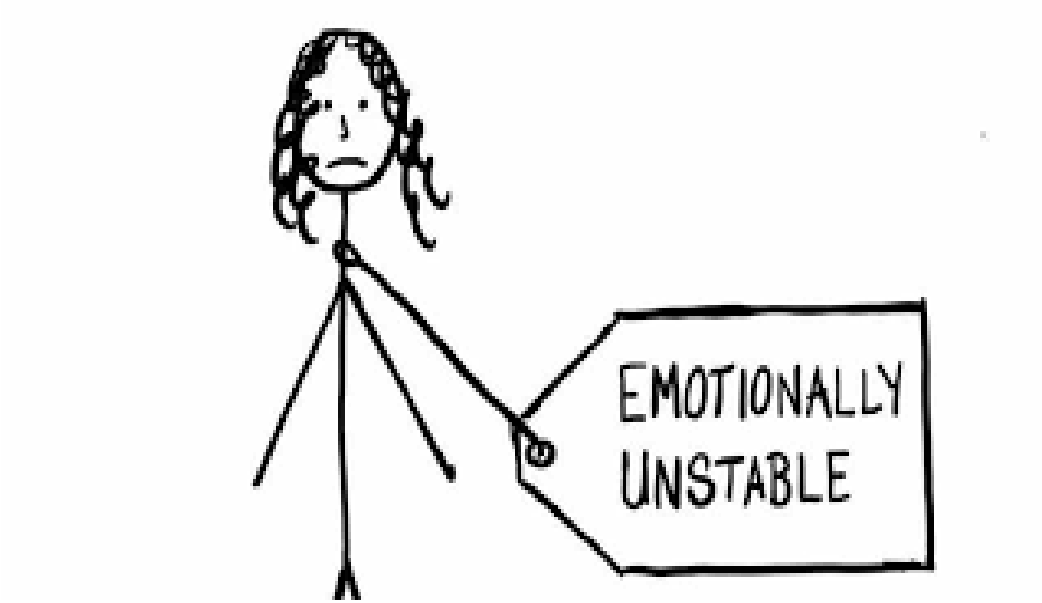
- The obvious – physical needs keep parent(s) awake day and night
- The baby cries and makes demands
- The infant is premature – multiple extra pressures w hospital visits etc
- The infant is deformed and there are many grief issues
- The infant looks like a hated family member who sexually abused
- The infant is normal and brings up multiple issues about the mother's own upbringing and how she was parented – UNREMEMBERED MEMORIES/MINI-TRAUMAS STORED AWAY FROM EARLY CHILDHOOD AND NEVER DEALT WITH – UNTIL NOW

Thoughts of harming/killing the baby

- Common eg 2022 study (Fairbrother et al)
  - 48% had unwanted intrusive thoughts
- 2.9% harmed their babies IRRESPECTIVE OF WHETHER THEY HAD HAD such thoughts
- Usual stats are 50+%

- I use the terms EGO- DYSTONIC and EGO-SYNTONIC which I discuss with the mother once I have made my assessment of risk

So the last diagnostic cluster:



- BORDERLINE PERSONALITY DISORDER AND EMOTIONAL DYSREGULATION

What is BPD (DSM IV & V) (and with an infant)

- **frantic efforts** to avoid real or imagined abandonment **THINK INFANT EFFECTS**
- a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation. **THINK INFANT EFFECTS**
- identity disturbance: markedly and persistently unstable self-image or sense of self.
- impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating) **THINK INFANT EFFECTS**
- recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior NB Self-harming of many sorts – cutting, eating, picking, tattoos, etc **THINK INFANT EFFECTS**
- **affective instability** due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days). **THINK INFANT EFFECTS**
- chronic feelings of emptiness
- **inappropriate, intense anger** or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights) **THINK INFANT EFFECTS**
- transient, stress-related paranoid ideation or severe dissociative symptoms

IMPACT OF BPD IN PREGNANCY
Pare-Miron (2016) and Blankley et al (2015)

- Gestational diabetes, OBESITY
- premature rupture of the membranes/requests for early delivery
- Chorioamnionitis
- Venous thromboembolism
- Consequences of substance abuse
- Preterm infants/ more special care nursery
- NB: ALL RETROSPECTIVE STUDIES

The impact of BPD on infants: the research

MANY PROBLEMS HOVING INTO VIEW

- **Kiel (2011**): mothers initially sensitive but sensitivity decreases, infant cries longer as doesn't feel validated**– INFANT CLEARLY DOES NOT FEEL VALIDATED, MOTHER MOVES INTO HER MIDBRAIN WEHRE SHE CAN ONLY EMOTE, NOT THINK – EFFECTS OF INFANT ON MOTHER AND MOTHER ON INFANT**

PROBLEMS CAUSED BY BPD:
Child and young adult outcomes

CRAP OUTCOMES

- **Macfie and Swann** (2009): 4- 7 y olds show shame, hostility, fear of abandonment
- **S. Stepp** (2011): a large number of internalising and externalising behaviours
- **Winsper** (2012): 11 yr olds: cognitive deficits, parental conflict
- **Barnow** (2006), **Herr** (2008): psychiatric, emotional, interpersonal difficulties
- **Lyons Ruth** (2012, 2013): BPD intergenerational transfer of problems in young adults especially with maternal avoidance

What happens to BPD mothers when they have infants? (Geerling et al, 2019, IMHJ)

- **Enter motherhood knowing they are fragile almost primed to be traumatised by their infant**
- **“Automatic maladaptive flight-fright responses including suicide attempts were common”**
- **“detrimental domino effect on close family”**
- **want to prevent the intergenerational transmission of attachment problems and BPD symptoms to offspring” and yet know there are insufficient services**

Some general issues about BPD and general practice

- **Incidence about 6%** but patients with BPD will disproportionately take up your time and your emotional energy – abandonment is high on the agenda
- Multiple physical co-morbidities: **OBESITY** (and therefore heart disease, diabetes etc), headaches, back pain, arthritis
- Multiple psychiatric co-morbidities: depression, substance abuse esp alcohol and cigarettes, impulsive behaviors

- REFERENCE: Borderline Personality Disorder in the Primary Care Setting, Dubovsky A, Kiefer M, Medical Clinics of North America, 2014, 98:5 Pages 1049-1064,
- AND NO RESEARCH ABOUT PERINATAL BPD AND GENERAL PRACTICE – Are you interested?

What the literature shows about treating BPD

MANY THERAPEUTIC MODES WORK and DO NOT USE MEDICATION (PS…WE ALL DO..)

- ❖ Mentalisation based therapy – MBT (Fonagy, Bateman)
- ❖ Dialectical behavior therapy – DBT (Marsha Linehan)
- ❖ Schema therapy
- ❖ Transfererence focused therapy (TFP)
- ❖ Good psychiatric management (GPM)

- Long term outcomes show some improvement over time, less well for women
- Is that because mothers have infants who disturb their emotions and then their sense of parenting competence and self-esteem?

(Oud et al 2018, ANZJP, Cristea in JAMA, Stoffers et al - Cochrane review)

So what can you do in general practice for your perinatal BPD patient

- **Make the diagnosis if you feel comfortable to do so or refer her for a one—off Item 291 psychiatric consultation for diagnosis and management plan – SOME WOMEN NOW COME AND TELL ME THEY HATE THEIR OWN ANGER**
- **Assess safety concerns (suicide/infanticide)**
- **Provide mother and her family with psycho-education about her condition and include partner and family as far as Mum allows eg Project Air website have marvellous information**
- **Don’t see medication as the cornerstone of treatment**
- **Suggest mum starts mindfulness eg through an app**
- **Find out what troubles the woman the most – eg that she cannot soothe her infant? Then help with that task is a great starting point (albeit not a simple solution) - from the BATHE technique in The Fifteen Minute Hour by Stuart and Lieberman**

More of what you can do to help the mother

- **Make sure you VALIDATE the patient as she may have been invalidated in her childhood**
- **Give her a technique to help when she is really losing it: RRRRR**
- **Make regular appointments, don’t just see in crisis**
- **Talk with your colleagues, your staff, other treating personnel as splitting can easily occur**
- **Talk with someone who can allow you to reflect eg in a Balint group**

Mum's formula: RRRRR

Re-Gard – baby cries, mother cannot immediately calm infant

Rupture – parent becomes upset

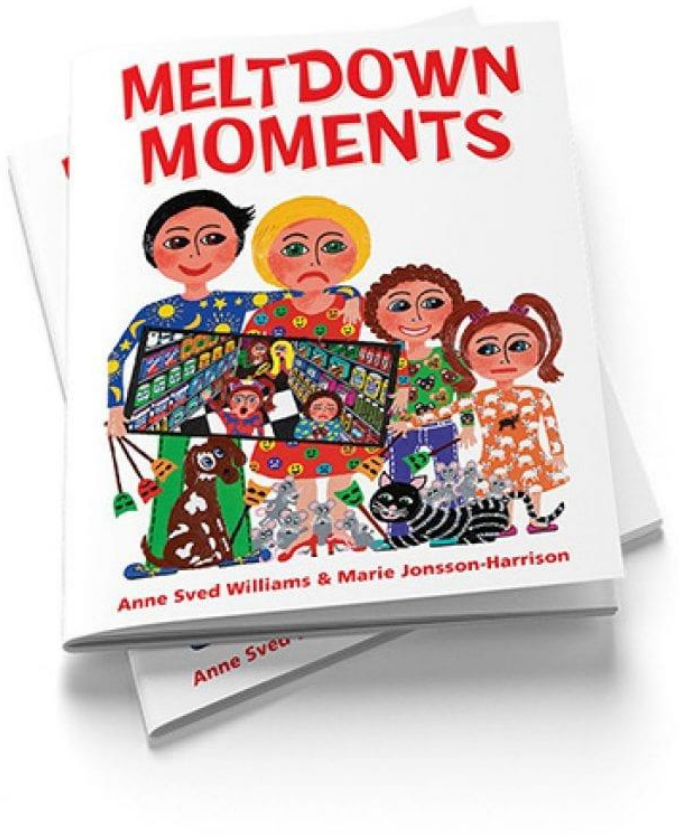
Re-Move – move away from problem

Re-mind – gives herself space to be **MINDFUL – using relaxation/mindfulness**

Re-flect – moves back into her forebrain and **THINKS** ABOUT A STRATEGY TO RE-ENGAGE

Re-pair – moves back with infant to help infant calm

And keeping the infant in mind…



1. Check physical and emotional development and provide developmental guidance and perhaps involve CAFHS
2. Observe and discuss the mother-infant interaction and keep the infant in mind – remember effects of infant crying on mother!
3. See if family members can help or can they afford child care?
4. Refer her for specialized therapies: Mother-infant dialectical behavior therapy (MI-DBT) or other people's programs eg Lighthouse, Parenting from the Inside Out, DBT programs
5. KEEP VALIDATING MOTHER!
6. Child protection services may need to be involved if serious concerns
7. Perhaps the family will find Meltdown Moments useful! On WCH Foundation website for $15

WHAT WE DO: DIALECTICAL BEHAVIOR THERAPY FOR MOTHER AND INFANT: MI-DBT

- **24 WEEK GROUP WHICH HELPS MOTHER LEARN SKILLS ABOUT EMOTIONAL REGULATION AND PARENTING IN A SAFE ENVIRONMENT AND ALSO HELPS HER TO FACE HER INFANT AND DO THINGS DIFFERENTLY**
- **REFERRAL THROUGH HELEN MAYO HOUSE**
- **AND OUR NEW 10 SESSION GROUP “LIFEBOAT” COMING EARLY 2024**
- **IF I EVER MASTER ETHICS…**

And what about you?

- Your mental health is IMPORTANT
- Do you have time for yourself – exercise, music, mindfulness, diet
- Do you have time for your family?
- Do you have sufficient opportunity for reflective supervision
- Your own GP or Doctors Health SA always on hand
- Balint group?

SUMMARY!

- PERINATAL MENTAL HEALTH DIFFICULTIES ARE COMMON, AND DESERVE ATTENTION FOR ALL FAMILY MEMBERS
- BIO-PSYCHO-SOCIAL APPROACH WORKS
- SO WORTH WHILE AS THOSE MOTHERS ARE SO ***MOTIVATED!***
- ***AND YOU MAY HELP THAT INFANT ALONG A BETTER LIFE PATHWAY!***