Psychiatric disorders in pregnancy

Depression, panic disorder, bipolar illness, and other psychiatric conditions can occur during pregnancy and should be considered when assessing the health of a pregnant patient.

Depression in pregnancy

During pregnancy, symptoms of depression such as changes in sleep, appetite, and energy are often difficult to distinguish from the normal experiences of pregnancy. Although up to 70% of women report some negative mood symptoms during pregnancy, the prevalence of women who meet the diagnostic criteria for depression has been shown to be between 13.6% at 32 weeks gestation and 17% at 35 to 36 weeks gestation (see the Table). The course of depression varies throughout pregnancy: most studies report a symptom peak during the first and third trimesters and improvement during the second trimester. In a recent study, more women became depressed between 18 and 32 weeks gestation than between 32 weeks gestation and 8 weeks postpartum.

Depression is the most common psychiatric disorder associated with pregnancy. Pregnant women may also suffer from anxiety disorders, such as panic disorder, obsessive-compulsive disorder, and eating disorders. While it is rare for women to experience first-onset psychoses during pregnancy, relapse rates are high for women previously diagnosed with some form of psychosis. (A full description of pharmacological and nonpharmacological therapies for these disorders will appear in Part 2 of this theme issue in April 2005.)

Several risk factors and psychosocial correlates have been identified as contributing to depression during pregnancy. The most clearly identified risk factors include a previous history of depression, discontinuation of medication(s) by a woman who has a history of depression, a previous history of postpartum depression, and a family history of depression. Several key psychosocial correlates may also contribute to depression during pregnancy: a negative attitude toward the pregnancy, a lack of social support, maternal stress associated with negative life events, and a partner or family member who is unhappy about the pregnancy.

Depression that is left untreated in pregnancy, either because symptoms are not recognized or because of concerns regarding the effects of medicatio-
between plasma levels of cortisol in the mother and in the fetus may have implications for the developing fetal brain.\textsuperscript{10} Treatments for panic disorder in pregnancy may include pharmacological therapies, particularly benzodiazepines for nighttime sedation and symptomatic relief, and antidepressants, as well as nonpharmacological therapies such as cognitive behavioral therapy, supportive psychotherapy, relaxation techniques, sleep hygiene, and dietary counseling.

Anxiety disorders in pregnancy

Data are available on some of the disorders that affect pregnant women (panic disorder and obsessive-compulsive disorder) but very little information exists regarding others (generalized anxiety disorder and social phobia).

Panic disorder

The course of panic disorder during pregnancy is variable and remains unclear. While case reports of pregnant women with pre-existing panic disorder have suggested a decrease in symptoms during pregnancy,\textsuperscript{7} large-scale studies have reported that there is no decrease in symptoms for women with pre-existing panic disorder.\textsuperscript{8}

In addition, a subgroup of women may experience first-onset panic disorder during pregnancy. Women presenting with panic attacks for the first time should be screened for thyroid disorder. The possible effects of anxiety and panic on the course of the pregnancy and the health of the fetus are not well understood. One study showed a correlation between increased anxiety and increased resistance in uterine artery blood flow.\textsuperscript{9} The correlation between plasma levels of cortisol in the mother and in the fetus may have implications for the developing fetal brain.\textsuperscript{10}

<table>
<thead>
<tr>
<th>Author</th>
<th>N</th>
<th>At 18 weeks</th>
<th>At 32 weeks</th>
<th>At 35 weeks</th>
<th>At birth</th>
<th>At 8 weeks postpartum</th>
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<tr>
<td>Evans et al.\textsuperscript{1}</td>
<td>9028</td>
<td>11.8</td>
<td>13.6</td>
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<td>8.1</td>
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<td>Josefsson et al.\textsuperscript{2}</td>
<td>1158</td>
<td>—</td>
<td>—</td>
<td>17</td>
<td>18</td>
<td>13</td>
</tr>
</tbody>
</table>

Table. Prevalence of depression in pregnancy.
and pharmacotherapy. Women with severe OCD can become quite incapacitated and will require treatment.

**Generalized anxiety disorder**
There are no data on the prevalence or course of generalized anxiety disorder (GAD) through pregnancy. Most women, naturally enough, worry about the health of the fetus and how they will cope with labor and bodily changes. Excessive worrying, however, may be a symptom of GAD or depression.

**Social phobia**
There are no data on either first-onset social phobia or pre-existing social phobia in pregnancy. A very small number of women experience toco-phobia, an unreasonable dread of childbirth.13 These women are more prone to postpartum depression if denied the delivery method of their choice (i.e., cesarean section).

**Eating disorders in pregnancy**
The prevalence of eating disorders in pregnant women is approximately 4.9%.14 While studies have suggested that the severity of symptoms may actually decrease during pregnancy,15 there are many negative consequences for both the mother and her infant. One recent study reported that pregnant women with active eating disorders appear to be at greater risk for delivery by cesarean section and for postpartum depression.16 In addition, eating disorders during pregnancy have been linked with higher rates of miscarriage and lower infant birth weights.17

**Psychoses in pregnancy**
The occurrence of new episodes of psychosis during pregnancy is extremely rare. However, for women with a history of psychosis, particularly psychosis in previous pregnancies, the relapse rates are high, with the most common manifestations being bipolar illness, followed by psychotic depression and schizophrenia.18,19

**Bipolar mood disorder**
The information regarding the course of bipolar disorder in pregnancy is limited. It appears that some women with bipolar disorder may experience a relief from symptoms during pregnancy, but that the risk for relapse in the postpartum period is high. One recent study reported that pregnancy had no impact on the course of bipolar disorder in women who discontinued lithium prior to conception, with the relapse rates for either depression or mania in the pregnant women being the same as in nonpregnant matched women.20 In another study, pregnancy appeared to have a protective effect against an increase in symptoms in women with lithium-responsive bipolar I disorder who had discontinued their lithium during pregnancy; however, there was a 14% rate of relapse in the last 5 weeks of pregnancy.21 In both studies, the risk of relapse in the postpartum period was very high, ranging from 25% to 70%. In women with a history of bipolar mood disorder, the decision whether to use mood stabilizers must be made following an assessment of risks and benefits. Factors to consider include number and severity of previous episodes, level of insight, family supports, and the wishes of the woman. Careful monitoring of psychological symptoms throughout the pregnancy is of paramount importance.

**Schizophrenia**
The limited data on schizophrenia in pregnancy suggest that this disease has a variable course, with some women experiencing an improvement in symptoms, while others experience a worsening of their illness.22 Regardless of the course of the illness, women with a history of psychosis require close monitoring by health care professionals during pregnancy. Psychosis during pregnancy can have devastating consequences for both the mother and her fetus, including failure to obtain proper prenatal care, negative pregnancy outcomes such as low birth weight and prematurity, and neonaticide or suicide. Treatment of acute psychosis in pregnancy is mandatory and includes mobilization of supports, pharmacotherapy, and hospitalization. Electroconvulsive therapy may be used for psychotic depression.
Summary
Early identification and treatment of psychiatric disorders in pregnancy can prevent morbidity in pregnancy and postpartum with the concomitant risks to mother and baby. Both psychotherapy and pharmacotherapy should be considered. In British Columbia, the Reproductive Mental Health program (www.bcrmh.com) offers consultation and education services to practitioners and allied health professionals throughout the province.

Competing interests
None declared.

References
Management of the pregnant woman with a psychiatric disorder should consider the consequences of fetal exposure to untreated maternal psychiatric illness, fetal exposure to psychotropic medications, and available alternative treatments [1]. Unfortunately, there are no risk-free decisions for pregnant women with a psychiatric disorder. However, the evidence predominantly supports present practice that ongoing treatment of psychiatric disorders in pregnancy is preferable to withholding treatment during gestation. Postpartum blues and postpartum depression (PPD) are in the section on depression.