DR. CLIFF MOORE: I am Dr. Cliff Moore. I am a psychologist. I work in an area called medical psychology that was being created actually back when I was in my doctoral program. They didn't really have medical psychology that much going on until the later 1980s. I was there in the middle '80s. And so basically people who do what I do were psychologists, but we treat medically ill people.

If you look at most us, most of us wanted had a real tough time deciding between being physicians or psychologists. And this was a way of having our cake and kind of eating it too. I'm the Chief Executive Officer for Behavioral Health Consultants. It's a large medical psychology group that provides all the psychology services for the Saint David's system. All five of the Saint David's-- is it five or six now? When we add the Heart Hospital. Six.

But we're in approximately 26 different facilities in central Texas. So we're kind of all over the place. Today I wanted to talk about a management of psychiatric problems during pregnancy. Believe it or not, once we created the women's center here at North Austin Medical Center, you wouldn't think there would be a whole lot of psychiatric issues there, but it's about my third busiest unit in the whole hospital. I'm there are a good bit of the time.

Psychiatric issues are actually very prominent during those periods. And we're going to be talking a little bit about ethical issues that arise when treating pregnant mothers. Is there anybody here that are on ethics committees now? I know you are. OK. A couple. OK. So you guys will kind of keep me honest when we start talking about ethical principles.

So also, this talk is usually much longer. We're going to be squeezing this into about a little bit less than an hour's time. About 45 minutes to allow some time for questioning. I reviewed the slides to shorten it up a bit, to condense it a bit, and ended up adding three slides. So much for the talk, I'm just going to keep going here. The objectives are a bit ambitious for the time that we have, but we want to talk about useful taxonomy for the psychiatric practice so we're all kind of on the same page and know what we're talking about.

Hello, Dr. Evans. We want to understand interventional options for these episodes and discuss current research regarding the use of psychotropic medications. That's what when we're talking about managing psychiatric crises in a hospital especially, that's what we get most of the questions about. And most of the ethical dilemmas that people find themselves in, they want to make sure they're doing the right thing.

And further, identify some ethical dilemmas associated with psychiatric crises during the perinatal period and then understand we're going to go over some basic principles of ethics that apply to these situations. And also especially one problem solving technique called relational ethics that we oftentimes forget to include when we're talking about crises during pregnancy.

So first of all, definition of terms. Perinatal period-- and the reason why I think we need to do this is because period terminology that are used by OB/GYNs are oftentimes used very loosely in the literature and by everybody else. So forgive me if you're an OB and we're a little less specific. But a perinatal period can be cumbersome when discussing the onset of psychiatric problems because perinatal is often used to describe early pregnancy through postpartum period.

And then peripartum, the last four weeks of gestation through a few months of delivery. Usually partum is considered after the birth. But what we have found is a lot of times psychiatric issues that are classified as postpartum actually began prepartum. And so when we're talking about really what are we concerned with oftentimes, or what physicians come to me and what they're concerned about, usually they're talking about medication affects because what they usually tell me is I'm just worried about medications because you're going to do the rest, right?

[CHUCKLES]

So what they're usually worried about is teratogenesis behavioral? In other words, am I going to do something that's going to cause this child later on to have some kind of neuropsychiatric problem. An example would be autism. Structural teratogenesis oftentimes in the literature we're talking about cleft palate and those types of things. Perinatal syndromes, floppy infant syndrome, apnea, lethargy, lazy at the breast, those types of things.

And then, of course, commonly associated side effects for the person taking the medication. So what do I recommend? Especially if you are an OB/GYN and you're not just a hospital's-- or besides being OB/GYN-- anytime you're seeing a pregnant mother-- really anytime you're seeing just about anybody-- when you're doing an intake, it'd be a great idea to take some form of psychiatric history.

And you can get a lot of what you need actually just with these few questions or at least just one or two of them. Have you ever sought services from a mental health professional? Have you ever been prescribed psychiatric medication by anybody? About 80% of psychiatric medication in the United States is prescribed by non-psychiatrists. Did you know that? Yeah. Only about one in five.

Have you ever been diagnosed with any form of mental illness. Have you ever even thought about it? When we make referrals from here, like for a patient that's inpatient, we do the best we can to hook people up with good mental health services outpatient and still anywhere from only about 7% to 15% of those people will complete the referral.

So you can imagine how many people aren't going without the urging of a group of health care individuals. Other screening things you can do, the patient health questionnaire too identifies anhedonia and dysthymia. It's just a couple of questions. Look for manic and hypomanic symptoms, anxiety, ask them if they abuse substances or use alcohol or do a tox screen if you can.

Any hallucinations that they may have. Sometimes those are quite obvious if they're having them right then. The not so obvious says they're not. And especially if they have no insight if those are hallucinations or not. And then any suicidal or homicidal thoughts, plans, attempts. And then you got to ask why is this happening now? No why is this happening to me?

Why is this happening now? One of the first things that gets beat into your head your first semester of being a clinical or counseling psychology student is why now? Why is this going on now? And during pregnancy, we see some that is precipitation due to pregnancy itself, preexisting psychiatric illnesses, pregnancy loss. And then these are not mutually exclusive things.

For instance, you can have someone who has a preexisting diagnosis of major depression, but they've being doing fine. They've been doing fine for the last six, seven, eight years. But then they experience pregnancy loss that triggers another depressive episode. Precipitated by pregnancy, why does that occur? Psychosocial stress, of course, of being pregnant.

Family involvement, of course, is very important. Hormonal, metabolic adjustments due to pregnancy. Patients are usually considered to be increased risk if they're young especially, under 20 years of age. If they're ambivalent about the pregnancy. Of course that a lot of times has to do with their social support, familial support. If they have a history of mental illness in their family or in themselves, of course.

And then what we find a lot of times is people will come, they'll say, look, I'm pregnant. Depending on what research you read, anywhere from 60% to 80% of pregnant women don't want to be on psychiatric medications. And they will either discontinue themselves or sometimes they're advised to do so by other people, including health care personnel. And what we see is a relapse when that occurs.

Then, of course, pregnancy loss, miscarriage. Miscarriage, at least in the American culture, is usually handled more internally with the family. It's not talked about as much. Pregnancy loss may be much more impactful, especially if it occurs at a greater gestational age. About 11% of women who have perinatal loss develop a major depressive episode. But if they have no children, that figure usually goes up to about 20% in the literature.

If they have a history of depression, you're talking about one in two within six months of pregnancy loss. And then like I said, the risk of depression is higher with groups for higher age groups and then the gestational age of the fetus at the time of loss.

And so now what do we do? If we know why now, then what are we going to do about it? First of all, if the OB is involved, a lot of OB's feel pretty comfortable-- sometimes uncomfortable-- with psychiatric medication depending on what's going on. Of course, a psychiatry consult is great. Unfortunately if the patient is in the hospital, there's not that much of an opportunity to get a psychiatry consult sometimes depending on where you're at.

But, of course, psychiatry consults can be done outpatient. Psychotherapy and behavioral intervention. If you're in Saint David's, you can call for a psychology consult. If they're outpatient and you feel like you want to make that happen, you can always contact one of us from Behavioral Health Consultants, we steer you in the right direction and help you make a good referral.

I brought plenty of business cards if you need one before you leave. And plus the people outside can tell you how to get a hold of me, as well. So sometimes if you can't get a psychiatry consult, you can call us in and we can help arrange all that. And then marshal support from community resources, get a social work consult if you're in the hospital.

And then we also sometimes have to consider psychiatric hospitalization if the patient is especially an imminent risk to themselves, imminent risk to the fetus, imminent risk to other people.

This in five I'll just mention briefly. The ideas in five just came out. It doesn't give us a very good way of talking about it. It was a bit of a disappointment to me regarding this subject matter. All they did was for peripartum they put a peripartum specifier in there for major depressive disorder and bipolar disorder types one and two. And then postpartum psychosis specifier for brief psychotic disorder.

They didn't really address psychiatric issues that could be precipitated necessarily by pregnancy specifically. And they didn't choose to discuss it as we normally talk about it in an obstetrics unit. So more useful taxonomy. Peripartum blues-- usually we discuss that as being people who are over 20 weeks but less than four weeks postpartum.

Perinatal depression, which it could be during the entire pregnancy plus four weeks postpartum. Postpartum psychosis. The peripartum blues usually happens in anywhere from 50% to 70% of women. Usually the onset is two to five days after the birth. And usually it resolves in a couple weeks even if we don't do anything. So the symptoms can include labile mood, irritable mood, as opposed to just dysphoria.

Dysphoria is just profound sadness. There can be frequent crying, but a lot of times it's more frustrating crying. Blues intervention, which I thought would be a great name for a blues group. And so I googled it and unfortunately it's copyrighted. So Marshall Walker, a really good blues guitarist for those guitarists out there, has a song called "Blues Intervention." Anyway, he robbed me of that.

The best thing to do with peripartum blues, it's a good idea just to educate the patient. Reassure them, encourage self care, have them get more sleep. You may have to marshal some resources around them. Dad may have to get up a little more with the baby or whoever's helping her take care of her. Get somebody to help take care of the baby. Better nutrition. Eating better.

Make sure they understand this is likely not a major depressive disorder and this usually resolves themselves. I'm not going to get into too much in to medical hypnosis right now, but also just playing that suggestion can be helpful because people view doctors as authoritative figures. So plan that suggestion that it will resolve will help. Stand by and be vigilant. And if you see them every two weeks, might be a good time to see them next week or later on that week just to make sure that they're OK and that we're not progressing into perinatal depression.

It unfortunately has the same symptom profile as major depression. Some people argue that it is major depression. But you dysphoria, irritability, sleep disturbances, can be insomnia, can be hypersomnia, appetite disturbance, anhedonia. Anhedonia is just Latin for "no fun." Don't want to go do the things that you normally do. Thanks, Jeff. If you're a doctor and you want to bill for it, say it in Latin. And it's anhedonia.

Fatigue, psychomotor retardation and agitation, and then concentration problems, indecisiveness and, of course, you can have guilt, worthlessness-- I'm not a good mother. I can't believe they let me leave the hospital with this baby. What were they thinking? I'm not doing well. And then suicidal audiation oftentimes occurs with depression. Not usually homicidal audiation, but suicidal audiation.

Not infanticidal audiation. It affects about 10% to 15% with a higher rate in teens and low socioeconomic groups. You remember back to a previous slide, younger patients, patients who have more psychosocial stressors like financial stressors. And, of course, there's bipolar disorder that affects only about 1% to 2% of women. But epidemiologically that is also the same percentage for men.

But women tend to have more episodes. Relapse rates have not been well studied. A lot of this hasn't been very well studied, actually, as far as pregnancy goes. But there about three times as likely to happen during pregnancy than not during pregnancy generally because medication for bipolar disorder often gets discontinued.

And the chance of relapse during pregnancy are about 50% for people pre-diagnosed with bipolar disorder. One in two. Again, though, that is heightened because medication often gets stopped.

AUDIENCE: Cliff, on that prospective trial, were they able to get a control group or was it just monitoring them prospectively as they went through therapy?

DR. CLIFF MOORE: Yeah. You know, almost all of this kind of research is done retroactively. So the control group is everybody who wasn't.

[CHUCKLES]

Yeah. It's very, very hard to actually do research with pregnant women and psychiatric issues. Exactly, yeah. It doesn't get past the ethics board. Bipolar interventions. We do have good results if you restart-- not restating. You can restate the medications all you want. That's been found to be very ineffective. Restarting-- sorry about that. You can restart the medications right after childbirth.

And that may preclude breastfeeding. I was raised on formula, I'm doing OK.

[LAUGHING]

Most of you are raised on formula. Cognitive behavioral therapy has been shown to be very effective in limiting the impact of bipolar disorder and depression. And in close monitoring, consider restarting the medications. There often has been a cost benefit analysis basically that you have to do. It might be better that the risks-- and we'll be talking about the risks shortly of psychotropic medications. You'll be surprised that they're probably lower than we think. There's according to the research.

But we might want to consider restarting the medication and maybe even hospitalization if the patient or the fetus or a newborn or anybody else is imminently threatened. And then consult. Especially with bipolar disorder, because you're usually talking about a cocktail. It probably is most important to consult there with that particular disorder. There are a lot of options we don't have time to get into all of them because there's quite a few.

But consult with psychiatry. They can be very helpful in figuring out what might be most effective for patient in that position. And then postpartum psychosis. Generally considered very rare. I say one to two every 2,000 births. It's more like one and a half every thousand births. Something like that. Women with bipolar disorder it occurs significantly higher.

Some studies actually say one in four with a preexisting diagnosed of bipolar disorder could result in a postpartum psychosis. But also know that that research is about 10 years old-- 10 to 15 years old. And psych has a way of having a diagnosis of the decade that people tend to get really diagnosed a lot as a certain thing. In the '80s it was borderline personality disorder.

In the '90s, bipolar started to take over. So I guess what I'm saying is you may have to be careful about the diagnosis of bipolar disorder. Sometimes people are diagnosed as bipolar and it may be something else. So it's always a good idea maybe to consult and have that diagnosis confirmed pre birth. And usually postpartum psychosis has an abrupt onset about three days to three weeks after delivery.

And, of course, prophylactic restarting of psychiatric medications can be very helpful. Actually, usually a lot of times it's the most effective thing you can do. And symptomology, confusion, audio visual hallucinations, delusional content, anxiety, agitation, labile moods, and then severe insomnia, and suicidal, homicidal audiation. Suicidal, homicidal audiation, especially the homicidal audiation and infanticidal audiation, this usually occurs within the context of the patient's delusions.

Oftentimes they are trying to save the child because if they don't kill the child they won't be able to go to heaven. If they do kill the child before a demon can get them, then they'll be saving the child. So a lot of times they feel like they're doing good. Or they feel like they've given birth possibly to the Antichrist and this child is going to destroy the world and they have to destroy the child first.

So you see a lot of that. And then treatment usually in that case would involve hospitalization. Not only for protection of the mother and infant, but also a postpartum psychosis can be very difficult to tease out as to what you're actually treating. Is it bipolar disorder? Is it some kind of depressive psychosis? Is it schizophrenia? Or is it just a brief psychotic reaction? And that is if we could have someone in a psychiatric facility monitor by psychiatry and psychiatric nurses and watch them over two, three, four days before we really start to split hairs as far as medications and diagnoses.

Now looking at medication, again, I'm a psychologist. I'm not a psychiatrist. So this is all research based, what I'm about to tell you. But a lot of times we've worried about anti-psychotics. We've worried about depressive medications. And I'm here to tell that the good news over the last 10 to 15 years, the research has shown that it's not as dangerous as we fret about for the most part.

Atypical psychotics. Even though the research can be scarce, there's more data for Seroquel, Risperdal, Zyprexa. Clauseril you'd want to avoid because it's been tied to major malformations and poor pregnancy outcomes. But also just as an aside, and I'll get into it in just a minute, but if we do nothing, we can cause a lot of problems as well. Not just from a direct result, of an obvious result, of someone who has a psychiatric crisis and we do nothing to intervene, but also because having a psychiatric crisis can oftentimes have the same effects that we worry about when we're looking at medication affects.

So something to keep in mind. We'll get into that a little bit later. Anti-psychotic effects again. They really don't support increased risks of congenital malformations like neural tube disorders or anything like that. There have been some studies that said well, it causes low birth weight or it causes high birth weight. Gestational age issues, in other words, they might be a bit preterm.

[INAUDIBLE], those are often conflicted and if you do nothing actually you see the same outcomes. You have low birth weights, poor gestational age, poor outcomes. You do have a higher risk-- especially with Zyprexa, you have a higher risk of gestational diabetes. SSRI effects, again, they don't appear to be teratogenic. There does seem to be a small risk of cardiovascular problems with paroxetine paxil. Paxil, you probably won't see that used a whole lot anyway.

I'm seeing fewer and fewer patients on paxil because of some of the side effect profiles that it might have. And then again, no conclusive evidence of neurodevelopmental effects. And if the patient or you want to discontinue the medication, it's best to do so slowly and be very careful as those things are waned because of side effects and withdrawal effects.

Before I get into the effects of no treatment too, even though a lot of the attention in research and in the media talk about postpartum depression, actually if you look at my caseload over in the women's center with pregnant women and postpartum women, you will see if you look at all the people who are depressed and anxious, it's about 50/50. If not, actually a little higher on the anxiety side.

How many OB/GYNs do we have in here? Just want to see. OK. Is that consistent with y'all's experience? Is that you see as much anxiety as you do depression nowadays?

AUDIENCE: I see more depression.

DR. CLIFF MOORE: You see more depression? OK. There may be some bias of what I get called in for a lot of times is as much anxiety as depression. So effects of no treatment-- oftentimes greater need for pain medications, higher postpartum psychiatric symptom rates, higher rates for preterm delivery, lower birth weight, decrease physical activity and attachment, and then increased fetal heart rate response to stressors. if we do nothing.

So intervention summary, I think it's important to have a careful cost benefit discussion with the patient regarding medications, their effects, the goods, the bads, the pros and cons. Of course, avoid abrupt discontinuation if at all possible. Use the least effective dose, and if you can use monotherapy. Keep it simple. And then try to do the best you can to increase the psychosocial support and clinical monitoring, cult console, refer.

And then, if you can, as early as you can, get a psychiatric advance directives. That can give you a lot of help in determining what to do if things go south as far as a psychiatric issue. I'm not sure if that got included in your packet. It did? OK. There may have been a form in there. If not. Believe it or not, there are a few psychiatric advance directive forms just on the internet.

But I would suggest if you download one of those, you have your own health care attorney take a look at that.

AUDIENCE: Texas doesn't have a form though. A lot of states have them but Texas doesn't.

DR. CLIFF MOORE: Texas doesn't. It's just something you would have for your office created by your attorney. Well, like I said, most advanced directives of course discuss end of life issues, but they don't necessarily discuss mental illness and what to do if the patient's declared incompetent. But it does provide some autonomy for the patient prior to a loss of decision making ability and guidance for us as clinicians.

When you're talking about ethics, some basic ethical principles I wanted to review before we get to a case presentation, nonmaleficence, autonomy, and beneficence. Justice really has to do with the quality, how we treat a patient. We have an obligation to treat patients equally without prejudice including those that have a mental illness. For instance, if a woman without schizophrenia has a right to refuse gynecological exam, or any kind of exam, so does a woman with schizophrenia.

Nonmaleficence-- we are obligated to avoid, of course, doing harm, we're usually worried about commission. I don't want to perform any act that is going to hurt hurt the patient. But we also have a problem with omission at times. We can cause harm by choosing not to treat. And often that is wrongly considered a safer route and it's termed omission bias.

Autonomy-- we're also obligated to respect the decisions of patients to accept or to decline medical treatments based on their values, their beliefs, their cultures, their priorities. And then, of course, beneficence-- so we promote the patient's best interest by choosing a course of action that most benefits the patient. But please keep in mind that the obligation of beneficence does extend to a fetus from a bioethical standpoint when the proposed treatment leads to a clear and overwhelming benefit.

But we have to make those determinations without coercion for the patient or paternalism. This case presentation really is a conglomerate of about four different patients. A couple that I've seen in the literature or a couple that I've seen here at North Austin Medical Center, I'm just going to read this. A 27-year-old woman with a history of major depression was married for four years, has a really good husband, was found to be 12 weeks pregnant.

And she had discussed a desire to become pregnant with her OB/GYN about four months ago. The patient was warned appropriately that her antidepressant medication was a class C medication. And with that information she decided to go ahead and stop that herself immediately. She went cold turkey. Had some withdrawal issues, that resolved after about four weeks. The patient then exhibited a great desire to maximize any benefit to her fetus, as most women do, who want to put her baby first.

She said she had never been more happy or more fulfilled in her life. Unfortunately, at about 23 weeks gestation she relapsed developing a severe depression. And she had profound guilt, doubting that she could ever be a good mom, and she said she was going to give the baby up for adoption possibly to a family member because they would be able to raise the baby better than she ever could.

She complained of insomnia, dysphoria, fatigue, isolation, poor appetite, poor nutrition, and significant hopelessness. She was having intrusive suicidal audiation but contracted very readily not to doing anything to harm herself because she didn't want to do anything to harm the baby. However, she declined to contract for safety once the baby was born. She had no psychiatric symptoms at all at the time. And so we talked about problem solving. What do we do now? When we're talking about ethical problems in a situation like this, I was always taught to paint the dilemma. It's this versus that. Has there been any sin of omission.

Well, possibly. If we didn't discuss with this patient that possibly continuing on the medication would've been a better bet because of the low risk-- as she was on SSRI-- that there was a low risk in giving a pregnant patient an SSRI, maybe that would be better for this patient to continue on their medication given her psychiatric history. We want to test the impact of mental illness is another problem solving technique.

I'll tell you about that in just a second. Relational ethics. And then possibly bringing in a substitute decision maker. So painting the dilemma. The problem that we have in this case particularly is autonomy versus beneficence. The mom wants to place the baby's needs before her own and that is natural for her to do. And she is choosing to actually do that. She has the right to choose that course.

Versus beneficence, force restart of the antidepressant medication as a risk of severe untreated depression could be outweighing the medication risks of the development of the fetus. Also we want to test the impact of mental illness on this case. In other words, if not for blank, would this even be happening? So if not for depression, would we be in this spot? And while it's normal for women to put their baby's health first, it is also common for depressed people to tend to find themselves worthless, to devalue themselves, to denigrate themselves, to blame themselves.

And really for this patient if not for severe depression, the mother would not be thinking of giving up her child or harming herself after the birth. Again, she was extremely happy prior to the onset of this depressive episode and felt fulfilled. She would also be able to better consider more information regarding ill effects of untreated depression on the fetus, on the birth process, correcting an earlier omission bias, possibly.

And, therefore, decision making ability has been compromised which increases the weight of the beneficence based approach. We also talk about relational ethics when we're talking about ethical problem solving. Oftentimes, especially in obstetric cases, we assume this us versus them stance, where the benefits to the mom are opposed to the benefits of the fetus.

And that is often not true. So considering relational ethics, what relational ethics would say is that it emphasizes the belief that actually the mother's and the fetus's best interest as far as beneficence goes are actually more intertwined and not truly at odds. It's a different way of seeing this.

In our case, it's really likely that once this depressive episode resolves, and we will certainly make sure that that happens, the mother is going to be very much injured by the fact that she has given up her infant. Therefore, treating the severe depression would be not only in the best interest of her, but likely in the best interest of the fetus. In problem solving this, an OB/GYN, for example, or a psychiatrist could even offer to ween the mother off the antidepressant medication.

Maybe not the best choice, but at least if you have to bargain. Weening with about two weeks prior to delivery, starting a ween and then restarting the medications as soon as delivery occurs. And then maybe it's possible at this time to bring in a relief pitcher. Again, if you have a psychiatric advanced directives, that person is usually already designated.

It might be a husband. It might be a sister. It might be a mother. I might be a best friend. It usually has to be determined by a mental health professional. Again, if the patient is in one of the Saint David's facilities, one of us will come and do it. A psychologist can do this just to see if the patient is of capacity or if autonomy has been compromised. And if found not to be of capacity, then the substitute decision maker can step forward and we can actually use them to help us tell us what to do.

Again, psychiatric advance directives makes that progress really simple. And I promised I would stop at 45 minutes and I did. So, phew. With two seconds to spare.