



Schizophrenia in the perinatal period

A guide for health professionals

Schizophrenia is a severe mental illness that is characterised by psychosis and associated with much stigma and misinformation. While some people with schizophrenia experience only one or a few episodes, for others it may remain a recurrent health condition.

Prevalence

The prevalence of schizophrenia in the general population is estimated to be **1 in 100**.

Causes

No single cause of schizophrenia has been identified, but several factors have been shown to be associated with its onset.

- Genetic factors – the risk increases to 10 in 100 among people with a parent with schizophrenia.
- Biochemical factors – imbalance of certain biochemical substances in the brain, particularly dopamine, is thought to be involved in development of schizophrenia.
- Stress – stressful events often precede the onset of schizophrenia.
- Alcohol and other drugs – harmful alcohol and drug use may trigger psychosis in people who are vulnerable to developing schizophrenia.

Symptoms

Major symptoms of schizophrenia include:

- delusions – false beliefs of persecution, guilt or grandeur, or being under outside control
- hallucinations – these most commonly involve hearing voices
- thought disorder – speech may be difficult to follow with no logical connection.

Other symptoms of schizophrenia include:

- lack of drive
- thinking difficulties
- blunted expression of emotions
- social withdrawal
- lack of insight.

Providing antenatal and postnatal care

Care planning

In planning care for women with schizophrenia, give priority to ensuring that health professionals involved take into account the complexity of the condition and the challenges of living with severe mental illness. Where available, involve specialist perinatal mental health services.

For women with schizophrenia, a multidisciplinary team approach to care in the perinatal period is essential, with clear communication, a documented care plan and continuity of care across different clinical settings.

Preconception planning

Preconception planning should start at diagnosis of schizophrenia among women of childbearing age.

Many women will have poor health literacy and will need clear explanations of the:

- importance of contraception if not planning a pregnancy
- effects of some medications on fertility
- risk of relapse in pregnancy or after the birth (particularly if medications are stopped)
- complexities of raising a child in the context of severe mental illness.

Preconception planning should include discussion of pharmacological treatments to be used after the birth.

This will involve decision-making by the woman about whether she will breastfeed.



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Antenatal care

Key considerations in providing antenatal care to women with schizophrenia include:

- monitoring for early signs of relapse, particularly as medication is often ceased before or during pregnancy
- education about nutrition and ceasing smoking, illicit substance use and alcohol intake in pregnancy
- monitoring for excessive weight gain and gestational diabetes in women taking antipsychotics
- referral for multi-dimensional care planning early enough in the pregnancy (particularly if the pregnancy is unplanned) to build trusting relationships and develop a safety net for mother, baby and significant others.

Postnatal care

Key considerations in providing postnatal care to women with schizophrenia are as follows.

- Women with schizophrenia may find the early postnatal period particularly distressing. Their bond with the baby may be compromised.
- Ensuring partner, family or paid (e.g. nanny) support is important, particularly overnight so the woman can sleep. Sleep deprivation is a common trigger for relapse so prevention is worthwhile.
- Careful monitoring is required in the first month after birth, with regular review in the following months.
- Consider access to specialist intervention to support parenting skills, including the role of partners and significant others, and attend to the mother-infant attachment.
- If relapse occurs, co-admission to a mother and baby unit is recommended. In some instances, it may be necessary for women to cease breastfeeding (if too unwell) and require night-time sedation.

Psychosocial and psychological therapies

Psychoeducation and supportive therapy that includes family and significant others is most important.

Cognitive behavioural therapy and other psychological interventions can be beneficial in managing secondary depression or anxiety.

Pharmacological treatments

Medications should only be prescribed after careful deliberation with the woman and her significant others when she is planning a pregnancy, is pregnant or breastfeeding.

Involving a psychiatrist is advisable.

Antipsychotics – While the evidence on the safety of antipsychotic use in pregnancy is limited, evidence from the general population supports their use to treat psychosis. However, clozapine is known to cross the placenta and the evidence on its safety in breastfeeding women is limited.

If considering use of clozapine in pregnant women, seek specialist psychiatric consultation.

Anticonvulsants – There is a risk of birth defects if anticonvulsants (particularly sodium valproate) are taken during pregnancy. There is uncertainty about the passage of some anticonvulsants into breast milk.

Do not prescribe sodium valproate to pregnant women.

Lithium – Antenatal monitoring of lithium levels is advised as requirements increase during pregnancy. There is potential for high passage of lithium into breastmilk and risk of infant toxicity.

Where possible, avoid the use of lithium in women who are breastfeeding.

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Tips for providing support

Listen and reassure

- Encourage the woman to discuss any symptoms she may be experiencing.
- Assure the woman that schizophrenia can be treated and managed.

Provide information

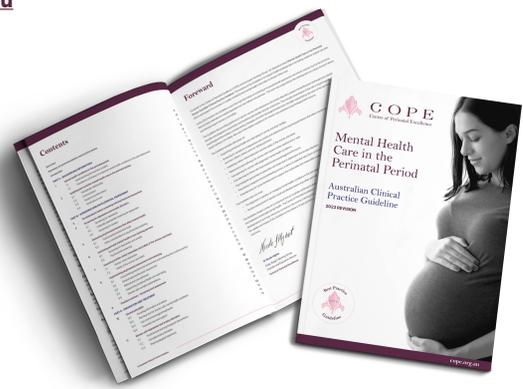
- Provide the woman with quality information about schizophrenia - see COPE consumer fact sheet.
- Provide details of helplines if she is feeling distressed and needs support.
- Offer information to the woman's partner/others.

Direct to care and support

- Encourage the woman to consult with her general practitioner (GP) or other qualified health professional.
- Encourage the woman to identify and draw on possible supports and services that may be available to her for practical and/or emotional support.
- Remind the woman that she can go to her doctor or local hospital if she is at risk of harming herself or others.

This resource was developed from the *Mental Health in the Perinatal Period: Australian Clinical Practice Guideline (2023)*.

The Guideline can be downloaded from the COPE website at cope.org.au



Information for women and their families:

Ready to COPE Guide:

Women and their partners can receive free weekly information about emotional and mental health throughout the perinatal period, via the Ready to COPE Guide. Visit readytocode.org.au for more information.

Information:

Provide women with consumer fact sheets on schizophrenia in **pregnancy** and the **postnatal** period.

Telephone support:

To access peer support person or health professional support and advice, call the **SANE helpline** on 1800 187 263 (Monday to Friday 10.00am – 10.00pm AEST/AEDT)

Further mental health information:

To find out about other perinatal mental health treatment and support services, visit the **eCOPE Directory**



COPE
Centre of Perinatal Excellence

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