

Review Article

Psychiatric Disorders in Puerperium

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Abstract:

Introduction: Post partum psychiatric illness was initially conceptualized as a group of disorders specifically linked to pregnancy and childbirth and thus was considered diagnostically distinct from other types. More recent evidence suggest that Post partum psychiatric disorder is virtually indistinguishable from psychiatric disorders that occur at other times during a woman's life. A wide variety of disorders are seen. Recognition of disorders for the mother-infant relationship is important, because these have pernicious long-term effects but generally respond to treatment.

Objective: The objective of this review is to highlight the different type of psychiatric disorders in the puerperium and their management.

Materials and Methods: Literature of reputed journals were used to prepare this article with the help of pshychiatric consultant.

Results: Psychiatric disorder in puperium has got different severity. Commonly encountered disorders are: Maternity blues, Post natal depression, Post partum psychosis. Most common is related to manic depression, in which neuroleptic drugs should be used with caution. Eighty five (85%) of women experiences mood changes in postpartum. About 10%-15% of women develops post partum depression. 0.1% -0.2% experience postpartum psychosis. 4,00000 children are born to depressed mothers every year.

Conclusion: The obstetrics team should alert both to possible interaction between psychological and obstretics factors and to the range of psychiatric disorders that may occur during pregnancy and puperium. The obstetrics and psychiatric teams should work together to improve their services locally and high light the need for greater service provision every where ic stress disorder, obsessions of child harm, and a range of anxiety disorders all require specific psychological treatments.

Postpartum depression necessitates thorough exploration. Cessation of breastfeeding is not necessary, because most antidepressant drugs seem not to affect the infant. Controlled trials have shown the benefit of involving the child's father in therapy and of interventions promoting interaction between mother and infant. Owing to its complexity, multidisciplinary specialist teams have an important place in postpartum period. It should have clinical priority those are suffering from psychiatric problem during puperium as they are in crucial situation. It is important to recognize earliar to avoid undesirable consequences, which are harmful both for mother and infant.. According to severity patient may need counseling, social support, sometimes patient may need hospitalization in severe cases. There are several traditional methods worldwide sometimes they are beneficial and sometimes harmful to mother and infant.

Key word: Psychiatric disorder, puperium.

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Introduction:

Recognition of psychiatric problems in childbearing women must become a clinical priority. Mental illness results from psychological breakdown following stress for reproduction where heredity is psychopathic. It is crucial that time for some interaction between mothers and infants be available, given evidence that the amount of contact between mother and infant following birth and the first days of life influences her attachment to and relationship with her baby¹. Women suffering from this kind of illness can also enter pregnancy when this conditions can be exacerbate or improve or remain unaffected². It is important not only because of undesirable consequences of such disorders for mother, but also because of their potential adverse impact on developing infant as well as on the rest of the family^{1,2,3}. In developed country great deal has been achieved in recent years to bring down rates of maternal and perinatal infant mortality and morbidity but rates of maternal postnatal mental illness have not declined in parallel⁴. If mother depressed postnatally then psychological development of infants can be adversely affected. Puerperium is the period which extends from parturition of baby up to 42 days. It is the time after birth in which mother's body, including hormones level, size of the uterus returns to non pregnant state. After birth of the baby, when it require for admission in critical care interaction between mother and baby is very important. This interaction may include showing the newborn to the parents before admission to the NICU, a visit with parents before transport to another hospital and still photographs, videos of the baby, specially if transported to another hospital^{2,3,4}. It has been shown that mothers have difficulty in forming an attachment when they have been separated from their babies during the first hours of delivery^{3,4}. Many factors influences the behavior of the mother. The widespread use of the tearms, postnatal depression and puerperal or post partum psychosis implies that these conditions are recognized clinical entities. Large meta analyses clearly demonstrate that between 10 and 15% of mothers are clinically depressed following childbirth, that is the gross burden of disease⁵. It is very important to try to sort out the women with chronic, long standing or recurrent depression who would have been present even if there had been no pregnancy^{5,6}. It may turn out that less than half of all cases of depression identified postnatally have an onset or recurrence in pregnancy or post natally. At the present

time the great majority of women who become depressed during pregnancy remain thus postnatally.

Incidence of mental illness is high in the first 3 months of delivery⁷. Overall incidence is about 15-20%. Two per 1000 mothers need psychiatric admission on account of a psychotic illness^{5,6,7}. Only half of them develop acute relapse following remission from a previous episode. Prevalence is determined by exposure to risk factors that precipitate or maintain episodes of disorder. The two most consistently identified risk factors are low socio-economic status⁸⁻¹⁰ and female sex¹¹.

Commonly encountered disorders are: Maternity blues, Post natal depression, Post partum psychosis^{12,13}. Maternity blues is not a disorder. It is recognized as clinical entity. Psychoneuroses form a collection of psychiatric disorders lies at between personality disorder and psychosis. These disorders are very commonly seen during pregnancy and the puerperium^{7,12,13}. Majority of these illness are self limiting and will recover by 6 months post partum, 30% of women are still ill at 1 year and over 10% at 2 year post partum. Long standing post natal depressive illness affects mother-infant attachment and relationships and interferes with the social and cognitive developments of children particularly marked in boys¹⁴. In long standing cases it may lead to breakdown of marriage. Maniacal tendencies can be more serious^{14,15}. Among all forms of psychosis, prognosis of reproductive psychosis is best as the condition is detected early and treatment is given promptly while the women lies under care^{5,14,15}. In this type of illness baby should be separated and breast feeding should be suspended if mother has got tendency for infanticide^{14,15}.

Neuroendocrine factors has got some role in psychiatric disorder during puerperium. Change in cortisol, oxytocin, endorphins, thyroxine, progesterone and oestrogen have all been implicated in the causation of illness^{11,15}. Changes in steroidal hormones have well known association with affective psychosis and mood disorders. It is not known whether puerperal psychiatric disorder are caused by the endocrine changes which occur during the puerperium or are an uncovering of an underlying psychotic tendency at a vulnerable stage of a woman's life. Psychotic episodes are most distressing not only for the patient themselves but also for their relatives and staff^{15,16}. The risk of suicide and safety of baby are paramount

consideration. Warning signs are very variable; features of danger signs are, confusion, restless extreme wakefulness, hallucination and delirium. It is important to bear in mind that someone can overlook possibility of an underlying organic cause such as acute puerperal infection¹⁷. Despite the wide spread myths of hormonal involvement, repeated studies have not linked hormonal changes with post partum psychological symptoms. Rather there are symptoms of a preexisting mental illness exacerbated by fatigue, changes in schedule and others common presenting stressor¹⁸.

Maternity blues:

Maternity blues is not mental disorder. It is transient mild form of mental illness. Nearly 50-60% of post partum women suffer from it. Maternity blues may only be dysphoric but there also may be mixed mild elation, occurs 4-5 days after delivery. Maternity blues can recognized by sinister sign^{16,18}. Etiological factors of this condition are, lowered triptophan level, sudden fall oestrogen, trigger hypersensitivity of E₂ receptors. Maternity blues is treated by mild tranquillizer and sedative at night if the women is tense anxious and insomnia is troublesome. Counseling in early puerperium about post partum mood change should be brought to the woman's attention, its frequent occurrence, metabolic endocrine basis and temporary nature emphasized.. Some mother will require considerable support. Reassurance and Psychological support by family members has got important role to prevent maternity blues^{12,18}.

Post natal depression (PND)

Postnatal depression was first reported as 10% by Pitt in 1968. It develops in early weeks following deliveries^{7,18}. Onset is not abrupt but slow. For early diagnosis specific enquiry should be made as to appropriateness of the mothers adaptational responses, eg. is the pregnancy accepted or is the baby accepted after birth etc. The most dangerous period is after the mother has left hospital following delivery. Manifestations are, early morning weakening, worse mood at morning, impaired appetite, lack of concentration, loss of interest and anhedonia^{15,18}. One third have intrusive obsessional thoughts of harm coming to their child. The women is unwilling to talk because she is afraid that the attendant may confirm her worst fears. Some women maintain a high anxiety state, being unable to integrate one or more of the sensory input from the environments or from their

own soma or psyche. The network of family and friends should be invited to help where appropriate, and beyond this, formal, social or other services may need to be helped. In case of possible chronicity, specially in a subclinical form, continued surveillance is wise¹⁸. Risk factors for post natal depression are past H/O psychiatric illness, puerperal psychiatric illness, chronic life difficulty, society adversity, marital conflict lack of confidence, unmet expectation. Obstetrics risk factors are - C/S difficult labour,, neonatal complications. etc. Cause of post natal depression may be changes in hypothalamo-pituitary- adrenal axis may be cause.

Treatment:

Women in the high risk group together with their partner should receive special antenatal education and counseling. Topics will include risk factors, emotional and social support and early features of decompensation. The changes in feeling during pregnancy and postnatal months will be discussed, together with the optimum changes in life style, diet, sleep home help and other support¹⁹. The most dangerous period is after the mother has left hospital following delivery. Peak manifestations occur between the 6th and 10th week after delivery. So counseling will able the main partner to suspect the nature of the disorder. In the form of behavioral therapy, there are number of techniques of relaxation therapy which can be offered. Most depend on the woman sitting into a comfortable position and relaxing maximally with each expiration. This may be preceded by sequential contraction of individual muscle groups for 5 seconds to heighten the relaxation effect. A woman should imagine that she is in the most relaxing environment in a bubble bath, on a billowing cloud, a warm, soft, sandy beach etc^{13,18}. Tricyclic antidepressant with minimal sedation is the drug of choice, particularly if the women is breast feeding. Starting dose of Tricyclic antidepressant 75mg at night increasing dose over few days upto 150mg. Improvement expected with in two weeks and resolution of illness between 4-6 weeks. Antidepressant should be continued for 6 months. *Hormones:* Progesterone therapy- Several authors suggest progesterone therapy but no data currently support the use of progesterone in PPD. Transdermal oestrogens- The recommended hormonal treatment is by transdermal oestrogens. Dose is 200 mg patches twice weekly. Large doses may be used. The equivalent dose of oestradiol gel such as 2.5 to 5.0 gms oestragegel twice daily is an alternative. Estrogen

will not suppress breast feeding once it is established. Estrogen that is present in breast milk have no adverse effect on the neonate regardless of gender. Transdermal oestrogen is not associated with venous thrombosis in the puerperium. This treatment can continue for as long as necessary, may be for more than a year¹⁸.

Risk of recurrence

Continuation of treatment for 6 months, the majority of women can expect to fully recovery.

Risk of recurrence is high 50-100% in subsequent pregnancies.

Adverse sequelae of post natal depression (PND)

Immediate

- Physical morbidity
- Suicide/infanticide
- Prolonged psychiatric morbidity
- Emotional development
- Late
- Social cognitive affects of child
- Psychiatric morbidity of child
- Marital break down.

If signs of early psychological breakdown are evident, referral for specialist opinion is indicated and admission preferably to a specialist mother baby unit may be required.

Puperal psychosis

These are Severe form of affective psychosis. One third are manic and two thirds are in depressive psychosis. Incidence is about 1% of pregnancies in 35-45% of women, the breakdown occurs predominantly or solely in the puerperium. In approximately 50% of these disorder appears among the woman has left hospital. Features are restlessness, agitation, confusion, fear and suspicion, insomnia, not eating, hallucination, rapidly forming delusional ideas about themselves and babies, etc¹⁶⁻¹⁸. Most common day of onset is day-5. Abrupt onset, usually disorder appears earlier in the puerperium than post partum depression. Nature of disorder are schizophrenic in type usually with a major affective component (depression); catatonic and paranoid features are predominate. Mother will display disturbance of thinking and emotional reaction. She will complain of intension for abnormal thoughts and it will be apparent that she has lost the ability to concentrate and organize. This leads to lack of concern and later

neglect of both herself and the baby^{5,15,18}. Overt illness is often precedes by personality deviations; which may extend to childhood. The mother is unable to discuss the future, she will express feelings of failure as another and perhaps suicidal thought. She may misperceive her child as abnormal. There is again a picture of neglect and non-coping. Manic features may be expressed in hyperactive behaviour which usually commences in the first puerperial week and peaks on later. Suicide accounts for 1-2% of all female deaths and approximately 4% of maternal deaths. The risk is higher if the woman has received poor mothering. Serious immediate prognostic factors include major recent loss and pessimism regarding the future^{13,18}. Predilection for the postpartum months suggest that the major endocrine/metabolic changes occurring at this time may be superadded to a genetic predisposition. There are in addition significant psychological stress at this time in adapting to the baby and its demands.

Risk factors for puerperal psychosis include family and or personal history of mental disorder, poor parenteral relationship, previous pregnancy break down, unresolved conflict, pregnancy acceptance, marital status etc. Poor personality integration, major obstretical complication, difficult baby, feed-refusing etc. Less important but additional problems are, poor family/social/cultural support, career conflict economic problems, heavy smoking and drug addiction^{6,12,18}.

Management

Early recognition and prevention includes adequate antenatal psychiatric history. Higher risk should be monitored correctly. Early warning signs like restless and in ability to sleep, depressed mood, thought and behaviour disturbances, anxiety, inability to do her work and cope, deteriorating relationship with partner etc. Have an prompt an immediate evaluation, perhaps including a home visit, and referral for consultant opinion if progressing beyond reasonable reaction to pregnancy and other experiences¹⁶⁻¹⁸.

If psychoses is present, management will usually be at specialist level, at least initially. Hospitalization is necessary in most cases. Psychotherapy may be given in the form of supporting analytical behavioural conjoint family and group therapy^{3,18}. Previously psychotic women are less likely to many, and if they do, the break-up rate is higher. Patient should be referred urgently to a psychiatrist. Usually required admission.

Drugs

Chlorpromazine-150 (mg) start and 50-150 (mg) three times a day is starting dose.

Sabliqual oestradiol 1 mg 3 times daily results in significant improvement.

In manic depression lithium is indicated.

In depressive psychosis electro convulsive (ECT) therapy is considered.

Recurrence risk 20-25% in subsequent pregnancy.

Electroconvulsive therapy usually used in bad depressive illness. The patient must be hospitalized. Whole procedure should be done under general anaesthesia. Electrodes are put on two hands and electric current passed through them. Due to passing current it causes seizure. Electroconvulsive therapy should be done for three to six weeks but its mechanism of action is not yet clear. During this therapy side effects are increase heart rate, blood pressure etc. The most panic information is that the patient may suffer from complete loss of memory²⁰. There are some postulations like,

Placentophagy

Although the placenta is revered in many cultures, there is scarce evidence that somebody customarily eat the placenta after the newborn's birth. Those who advocate placentophagy in humans believe that eating the placenta prevents postpartum depression and other pregnancy complications. Obstetrician and spokesperson for the Royal College of Obstetricians and Gynaecologists Maggie Blott disputes the post-natal depression theory, stating there is no medical reason to eat the placenta; "Animals eat their placenta to get nutrition - but when people are already well-nourished, there is no benefit, there is no reason to do it. Human placenta has also been an ingredient in some traditional Chinese medicines, including using dried human placenta, known as "Ziheche" to treat PND, wasting diseases, infertility, impotence and other conditions²¹.

Meroyan

In Malaysia postnatal depression is called Meroyan. It is low 3.9%. Confinement period is 6 weeks. Three major feature in Malayan post natal care included, use herbs, use heat, Malay postnatal massage. They used herbs both internally and externally. They use internal herbs in the form of decoction, capsule or grounded and cooked with honey. They use external herbs in

the form of herbal bath by using herbal paste and extracts added to ointment. Regarding use of heat during PND they may be exposed to heat directly or indirectly. Exposure to direct heat by heated river stone and warm herbal bath and indirect exposure to heat done by consumption of hot foot. Malay postnatal massage has got special criteria. It may be whole body massage, hot compression and wrapping of whole body. The frequency of massage about 6 to 7 times during confinement period²².

Indian's Myths

Their traditional belief is that if they wear new sharies and paint their hand by Hena just like bride before delivery this will ensure easy delivery and there by prevent postnatal depression during puerperium²².

Conclusion

The obstetrics team should alert both to possible interactions between Psychological and obstetric factors and to the range of psychiatric disorders that may occur during pregnancy and the puerperium. Despite of increasing recognition of puerperal psychiatric disorders, there is relative negligency of pre existing psychiatric disorders in pregnancy, with chronic, severe mental illness requiring particular focus, knowledge and liaison regarding the use of psychotropic medication in pregnancy and the puerperium are vital. The importance of realistic risk benefit assessment in every patient is emphasized^{15,16}.

We hope that obstetrics and psychiatric teams can work together to improve their services locally and highlight the need for greater service provision everywhere.

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