Psychiatric Disorders Associated to Post-partum Period

Mihaela-Luminița Staicu[1], N. Costin[2]

1. Assistant Professor, Department of Medical Psychology, "Carol Davila" University of Medicine and Pharmacy, Bucharest
2. Professor, Department of Obstetrics and Gynecology II, "Iuliu Hațieganu" University of Medicine and Pharmacy, Cluj-Napoca

Correspondence: Mihaela-Luminița Staicu
e-mail: mihrud@yahoo.com

Abstract

Childbirth, from the psychological medicine perspective, is the most complex human experience. Pregnant women and those who recently gave birth are prey to a variety of psychiatric disorders, which are not easily recognized. Thus, the present paper aims to make a short presentation of these disorders, based on a number of studies published during the last years and which presented the various types of post-partum reactions. Considering them as physiological and not treating them can negatively affect the mother, the child or alter their interaction. The authors concluded that the post-partum period, as described by the scientific literature, is characterized by an extreme vulnerability and that it is very important for future mothers to be well evaluated, to be educated in order to identify early the symptoms and to get proper treatment.
Keywords: *post-partum, anxiety, depression, blues, puerperal psychosis*

Introduction

Childbirth, from the psychological medicine perspective, is the most complex human experience. Pregnant women and those who recently gave birth are prey to a variety of psychological disorders[(1)]. Post-partum period is characterized by an extreme vulnerability to an entire spectrum of psychological disorders.

In 1838, Esquirol, followed by his disciple Marcé, are those who created the first coherent corpus of knowledge related to puerperal mental disorders. After the World War II, research in this area followed a new direction; the study of the interaction between the mother and her child lead to a better understanding of these disorders and of their impact on the child. In 1948, in United Kingdom, Main hospitalizes for the first time a depressive mother and her child and in 1959 Baker creates the first psychiatric unit that allowed the hospitalization of mothers and children, due to delirious disorders. In 1952, in USA, Maloney describes the "post-partum blues" phenomenon, and in 1968 Pitt writes about "atypical post-natal depression" and establishes its incidence, which is far more common than anticipated. These researches and information will contribute to the establishment of a new special field called "perinatal psychiatry"[(2)].

The present paper makes a short presentation of the various psychiatric disorders that could affect the mother during the post-natal period, as they were described by the scientific literature: anxiety and depression, blues or puerperal psychosis and it presents the results of some recent studies that investigate the frequency of these manifestations during the post-partum period. Our objective is to highlight the incidence of these disorders and the importance of the psychotherapeutic approach in order to discover the early symptoms and to offer women an adequate treatment.

Post-partum disorders

Anxiety disorders

Motherhood represents a risk factor for anxiety pathologies (panic disorder, generalized anxiety, obsessive compulsive disorder etc.) both during and after pregnancy. Post-partum period is very often characterized by an aggravation of preexistent disorders.

According to Dayan (2007), the incidence of anxiety disorders during post-partum has been estimated between 10 and 16% for isolated disorders and between 2 and 4% for those associated to a depressive pathology. The scientific literature warns about the fact that post-partum anxiety disorders that last more than one year are likely to modify the child evolution, leading to behavioral disorders and affecting his social interaction[(2)].

The obsessive-compulsive disorder, specific to post-partum period, is characterized by obsessions and, sometimes, by rituals. The impulsive obsessions are the most specific, being characterized by the fear, terror even, of accidentally or compulsively killing the new born. Dayan (2007) affirms that the obsessions manifest themselves as interrogations (If I breast feed the child, can I suffocate him? Will he drawn if I bath him?) and phobic obsessions are often represented by the anxiety of the child's sudden death. Frequently, shame and culpability occur which can lead to impaired child care for fear of not harming him. The disorder does not characterize only the early post-partum, sometimes it lasts for more than one year[(2)].

The generalized anxiety disorder made the object of interest of many researches, its frequency being estimated between 6% and 8%, but an incomplete simptomatology can be detected in up to 20% of women, during post-partum period[(2)].

Brockington et al. (2006) investigated the types of anxiety experienced by mothers during the post-natal period. They noticed that after birth, the fear

related to baby's health and safety was the most common morbid anxiety. This reaction is called "maternal separation anxiety". The most severe post-partum fear is the child's sudden death and the fear of criticism. 16% of women were also suffering from post-traumatic stress disorder, but only 5% of them were confronted with the symptoms for more than 4 months. According to Brockington et al., the stressing experience was usually related to pain, lack of control and fear of death[1].

A recent research, published in Journal of Affective Disorders in 2010, investigated the role of panic disorder as a risk factor for post-partum depression. 600 women from Pisa (Italy) have been recruited; they were in their third month of pregnancy and have been followed until the 6th month after delivery. The panic disorder during pregnancy and the personal and family history related to panic disorder have been identified as risk factors for post-partum depression. The authors note that panic disorder is a very serious condition because it can be associated with other psychological disorders especially with major depression. Patients who suffer from panic disorders associated with depression are confronted with a more severe severity of symptoms and with a poor response to psychotherapeutic and pharmacological treatment. Also, panic disorder is an independent risk factor for suicidal behaviors[3].

The same researchers investigated the role of anxiety disorders in post-partum depression and they concluded that the manifestation of a panic disorder was associated with a higher probability of minor or major depression during post-partum. Especially women with obsessive-compulsive and panic disorders were confronted with a higher risk of developing depressive symptoms during post-partum as opposed to women who were not confronted with this kind of anxiety. As for the risk of developing post-partum depressive disorders, a positive association was found in the case of women with panic disorders[4].

Post-partum blues

According to DSM IV this transient emotional disorder is affecting up to 70% of women, especially between the second and the tenth day after delivery. Women have to face a variety of stressful physiological and psychological events. The birth of a child imposes an almost instant adaptation to an event that requires a new drawing of the identity; it redefines social roles and the body image[2].

The disorder usually lasts less than 24 hours, it varies between several hours and several days. The mother cries for no apparent reason or for minor things. The crying can be also associated with a state of depression, anxiety or irritability. Often, she can pass from anxiety to excitement. Often, we see fluctuations of mood disorders as well as immediate memory loss or lack of attention[2].

The severe blues, characterized by depersonalization - which can occur immediately after birth, or between the 4th and 7th day post-partum - and excitement, sometimes accompanied by confusion, hallucinations and strange behavior is a different type of disorder. Its short duration distinguishes it from puerperal psychosis. The early blues, manifested a few hours after delivery, affects 10% of women[2].

Chabrol et al. underline the fact that severe blues allows the detection of mothers with risk for post-natal depression and it can allow intervention in order to prevent it from developing. Scientists assume the fact that the blues is biologically determined, being caused by hormonal changes after delivery. But it is also possible to be aggravated by psychological reactions such as anxiety or culpability. The tendencies of aggression towards the new born are extremely disturbing for the mothers. The authors underline the fact that research has established that information concerning the frequency of blues and its manifestation could prevent or reduce anxiety or culpability reactions[5].

In order to validate this idea, Chabrol et al., researchers at University of Tolouse, conducted a study with the participation of 37 women, who were in their third pregnancy semester. The women were divided in 3 groups. The first group received written information about post-partum blues, the second oral and written information and the third was the control group. All participants completed the Edinburgh post-natal depression questionnaire in the 3rd and 5th post-partum day. By comparing the groups that received information with the control group, the authors revealed that informing mothers before delivery reduces the intensity of post-partum blues. The 2 intervention groups suffered comparable effects: the group that received written and oral information did not demonstrate a higher prevention effect as compared with the one who received only written information[5].

Post-partum depression

Ever since the '80s, research on post-partum depression has grown; post-partum depression is a pathology situated between adult and child psychiatry. According to Chabrol et al., this psychopathological entity which usually occurs from the 4th week after delivery, is affecting between 10 and 15% of new mothers[5]. But this estimation is almost entirely based on researches conducted in developed countries and some epidemiological studies suggest that the incidence of post-natal depression could be higher in developing countries[7].

Post-partum depression is a real public health problem, especially because the largest part of mothers is not aware of this disorder. They tend to hide their suffering, as they want to avoid being labeled as unfit mothers and they blame their difficulties on fatigue[6]. When these anxieties persist, they become extremely uncomfortable for the mother and the risk of neglecting the child increases. The mother or her family often does not recognize the symptoms, as

the birth of a child is by definition a happy event. Teissedre et al. underline the fact that research has proven that only a half of these depressions are properly diagnosed by physicians or other professionals from the health system and that only 1/3 of diagnosed mothers follow the treatment[8].

The literature on post-partum depression identified some risk factors. In addition to the classification made by Dayan (2007) the following factors resulted[2]:

- **Psychiatric factors:** history of depression- bipolar discorder included[9], post-natal or whenever during the life, pre-natal anxiety and depression, are the most important risk factors. Stressful events, others than pregnancy, delivery and eventual complications make mothers more vulnerable to post-partum depression;
- **External factors:** stressful events, such as domestic violence during pregnancy or during postpartum, childhood sexual abuse, make the mothers more vulnerable to post-partum depression;
- **Socio-economic factors:** poor social support, lack of education, unemployment. Mothers with low incomes are more likely to post-natal depression and many times, unlike middle-class mothers, they do not seek treatment to overcome this condition[11];
- **Gyneco-obstetric factors:** caesarian operation can lead to a profound depression. The accidents that jeopardize the life of the mother, neonatal complications[9] or severe hemorrhages during delivery can lead to severe stress. The place of delivery does not influence blues or depression (according to Dayan, in Holland, 1/3 of women deliver at home, as opposed to France, where this happens in less than 1% of the cases).

Socio-economic factors and conflicting family relations favor a low self-esteem and little confidence in the maternal qualities.

The main signs of post-partum depression are: crying, exhaustion, fatigue, asthenia, insomnia, the feeling of incapacity to respond to the child's needs, loss of pleasure to take care of the baby, irritability and sometimes aggression directed towards the husband or the other children, emotional liability, loss of libido and impulsion phobias (obsessive fear to commit impulsive gestures that could lead to the death of the baby). Mothers may have ideas of suicide, homicide or delusions about the infant.

Between 20% and 40% of the cases of post-natal depression begin during pregnancy[2]. Consequently, post-partum depressions can be detected and treated as soon as possible. One of the most used detection instrument is Edinburgh Postnatal Depression Scale (EPDS), a questionnaire of 10 items, with scores between 1 and 30, allowing the early detection of depression and of post-partum depression[8].

The results obtained by Teissedre et al., that conducted a study using EPDS during the 3rd day after delivery and the 4th and the 6th week after delivery revealed that 18,1% of mothers were suffering of post-partum depression. This fact confirms that the intensity of depression manifested the 3rd day after delivery can predict post-partum depression so, this disorder can be detected in time; this is a very important discovery if we take into account the consequences that post-partum depression can have on the mother- baby relationship, on the child's development and on domestic and social relationships[8].

According to longitudinal studies, children with depressed mothers develop low cognitive, neuropsychological, social and emotional abilities during childhood and adolescence[10]. Post-natal depression has been associated with negative outcomes on the baby. A research published in 2009 investigated the relationship between post-partum depression and the use of methods in order to prevent the risk of accidents for their children. The study compared 60 women without post-partum depression symptoms with 74 depressive women (the EPDS questionnaire has been used in order to identify them). Depressive mothers went less frequently to the doctor for medical visits, they did not use devices to protect their children against accidents, they did not have knowledge about healthy nutrition, they did not immune their children and they used corporal punishments[12].

Postpartum depression is frequently associated with panic disorder and obsessive-compulsive disorder, which worsens the prognosis[13].

Reactive depression may occur following an abortion, sudden fetal death, after a difficult pregnancy or a complicated birth, when the baby has severe abnormalities or when the family refuses to accept it. Diagnosis of this type of depression requires: the existence of a traumatic event, the persistence or reduction of the depressive symptoms after a period of time, the emergence of ideas of low self-esteem, worthlessness and even autolysis[14].

Puerperal psychosis

This collocation designs an ensemble of delirious manifestations associated with brutal humor changes; it usually appears during the first 15 days after delivery, but it can last even a year. It represents the most severe post-partum psychiatric manifestation.

According to Dayan (2007) the estimated incidence is of 1 or 2:1000 births and it represents an emergency because of the high risk of suicide and infanticide. In United Kingdom, 28% of maternal deaths during perinatal period are the result of a suicidal act, half of these being committed by women with psychiatric history, especially puerperal psychosis and bipolar disorders. None of these acts has been committed in specialized psychiatric units[2].

Dayan (2007) underlines the fact that the risk factors for puerperal psychosis can be classified in several categories, such as[2]:

- **Psychiatric factors:** family of bipolar disorder or puerperal psychosis and especially a personal history

of bipolar disorder represent the main factors: the risk is estimated at approx. 10% in the case of family history and 30-35% for personal history. It is frequent for the disorder to be preceded by non-psychotic symptoms during pregnancy, especially for episodes that manifest during the first 2 weeks of post-natal period: 75% of the subjects are confronted even from the pregnancy with anxiety and depressive symptoms. 30% of mothers with puerperal psychosis suffer of bipolar disorder as well[9];

- **Gyneco-obstetric factors:** 70% of psychoses are manifested among primiparous women.

Maniacal symptoms and mixed humor, especially at the beginning are characterized by rapid alternations of maniacal and melancholic elements with relative calm episodes. They are often preceded by lack of sleep, severe or even total insomnia. The mother manifests a total lack of interest on the baby and she keeps him at distance. After this initial phase, the mother experiences intense agitation, psychotic disorganization, frequent and delirious hallucinations. Severe delirious psychosis are initially characterized by: lack of sleep (nightmares and agitation), anxiety, bizarre behavior, lack f interest and progressive aversion in what concerns the corporal contact with the baby, crying episodes, asthenia, somatic pains. The anxiety grows rapidly. Delusions, of paranoid type or of guilt/sin[9], or of child possession occur during the first three weeks after birth. The perception of reality or the self consciousness are disturbed[2] and the mother might have imperative hallucinations that order them to harm the child[9].

The infanticide is an extremely traumatizing criminal act, with severe psychopathological, social and familial repercussions; it is characterized by a plurality of aspects and by the frequency of dissimulated cases. Rammouz et al. warn about the fact that a number of studies demonstrated the fact that 43% of patients presenting puerperal psychosis think about infanticide. This is why these patients require a close surveillance[15].

A proportion of "sudden deaths" can be associated with hidden criminal acts. An Indian study, conducted with the participation of 50 women admitted for post-partum disorders, revealed that 43% of them had infanticide ideas and 4% had already committed such an act[15].

Spinelli, quoted by Rammouz & al. revealed that mothers that committed infanticide showed clear symptoms of depersonalization, hallucinations and intermittent amnesia during the first days after delivery[15].

The incidence of infanticide, the reasons and the circumstances of committing such an act varies among cultures and societies. According to Rammouz et al. the scientific literature proved the fact that neonatal infanticides are committed by women between 30 and 40 years old. Multiple births, lack of affection and low income represent risk factors. Female new born are more affected by this type of crime especially for religious, cultural and economic reasons (India, China etc)[15]. Most of the studies revealed the fact that mothers often appeal to suffocation. Lewis et al, quoted by Rammouz et al. discovered, in a study conducted with the participation of 60 women accused of infanticide, that 25% had used a weapon and that infanticide acts committed with a lethal weapon are associated with severe psychotic disorders[13].

Postpartum psychiatric disorders are linked to hormonal changes (progesterone, estrogen, cortisol and thyroid hormones) and to psychosocial adaptation process (social status modifications, changes in interpersonal relations, in normal conduct and rhythm)[14]. They can take a variety of forms, from anxiety disorders, obsessive-compulsive disorder, depression and blues, to various forms of psychosis. Left untreated, mental disorders in the post-birth period can affect the child, the mother and the interpersonal relationship between them. The cognitive, neuropsychological, social and emotional development of the child is disturbed if the mother suffers from mental illness. Also, intra-familial relations are affected, situation that amplifies the negative effect on children.

To avoid the occurrence of these types of disorders, it is important that mothers be informed of situations that may arise, that the obstetrician or family physician recognizes these nosological entities, to conduct psychological and psychiatric evaluations of women at risk for that they receive professional help quickly. ■

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