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EDITORIAL

PSYCHIATRIC DISORDERS OF PREGNANCY AND THE PUERPERIUM

Pregnancy and puerperium are emotionally stressful periods. Most women do come through the pregnancy and the subsequent months with a sense of triumphant enrichment. Yet, mood swings and mental disorders are particularly prone to occur during the pregnancy and lactational period.

It is difficult to estimate the incidence of psychiatric disorders during pregnancy and puerperium, but their understanding has twofold significance. Firstly, many of these women require specialised psychiatric care, yet a pregnant or puerperal woman who becomes acutely disturbed requiring emergency treatment, is encountered first by her obstetrician, who has to manage her till expert psychiatric consultation is available. Secondly, a little effort during first antenatal check up may

be able to bring up likely candidates who might develop psychiatric problems during pregnancy or puerperium or both A family or personal history of psychiatric illness or disorder, problems of emotional adjustment during puberty, history of early maternal death or deprivation, conflicts about-mothering marital conflicts including separation, past history of abnormal mood changes in pregnancy, labour or postpartum depression and recent death of a near and dear one, a long history of infertility prior to conception, repeated abortions, prior foetal deaths, history of giving births to congenitally malformed babies, history of current or past sexual, physical or emotional abuse and history of premenstrual syndrome, are a few aspects which should be inquired into.

Unanimity still has not been reached whether psychiatric disorders during pregnancy and puerperium are the same or different than those appearing at other periods of life but there is no disagreement that more serious disorders commonly develop during the two to four weeks postpartum. Also, psychiatric disorders are fundamentally similar in the antenatal or postanatal period and may occur in association with the first or subsequent pregnancy.

The common psychiatric disorders met during pregnancy and/puerperium are (1) Depressive or affective disorder (2) Postpartum psychosis (3) Anxiety disorders of pregnancy.

DEPRESSIVE OR AFFECTIVE DISORDER:

This is characterised by a specific set of symptoms associated with a change in mood. This lasts for a period of at least two weeks and is severe enough to interfere with activities of daily life. The severity can vary considerably from a very mild transient period of feeling 'blue' to major clinical depression with vegetative signs and symptoms to severe psychotic depression with hallucinations, delusions and a suicidal tendency. Treatment consists of support from husband, family and health care providers.

POSTPARTUM PSYCHOSIS:

The incidence is 1-2 per 1000 births. There is severe mental illness frequently requiring admission in psychiatric ward because of delusions and concern that the woman might harm herself or the newborn. Risk of recurrence in subsequent pregnancy may be as high as 20% - 30%. Symptoms develop most commonly from a few days to 4-6 weeks post partum, although a careful history often reveals beginning of the symptoms in the third trimester of pregnancy. The symptoms which usually follow after delivery are confusion, sleep disorders, increased

emotional liability, usual behaviour and obessional or delusional thinking. Antidepressant drugs or lithium is used for treatment along with proper care in psychatric ward. Breast feeding is discontinued in women with drug therapy. Schizophrenia, organic brain dissease, drug dependency and thyroid disorders should be ruled out before diagnosing postpartum psychosis.

ANXIETY DISORDERS OF PREGNANCY

Anxiety during pregnancy and puerperium is normal phenomenon. Its total abscence is as pathologic as its excess. They are of following types.

1. Phobic Disorders - include persistent and irrational fear of a specific object, activity or situation. In pregnancy, women with these disorders have irrational fears e.g. non substantiated worries about food that might harm the fetus. Treatment ranges from simple reassurance to behaviour modification.

2. Panic Disorders - include recurrent attacks of anxiety with sudden onset of intense fear and apprehension. It may be a part of the syndrome of depression.

3. Patients with obsessive compulsive disorders - have ideas or thoughts that make them do or overdo certain things. Diagnosis and therapy by a mental health profesional is usually necessary.

4. Post traumatic stress disorders - develop after a known traumatic event. The individual may recurrently experience thoughts or dreams and the symptomatology may include sleep disturbance, hyperalertness, guilt and memory impairment. The posttraumatic event may be a stressful labour and delivery, fetal loss, infertility or the death of a close relative or friend. When counselling a woman with any of the above disorders, the clinician needs answers to following questions : (1) Is there a medical condition causing the disorder e.g. an endocrine problem? (2) Is there a basic psychiatric disorder such as depression or Schizophrenia present? (3) Is this patient abusing alcohol or other drugs? Consultation with a mental health professional is recommended.

GENERAL GUIDELINES FOR MANAGEMENT OF PYCHIATRIC ILLNESS IN PREGNANCY AND LACTATION

Psychotropic drugs should be avoided if at all possible during pregnancy and lactation but often they do require medication. Non-pharmacologic methods such as psychotherapy, cognitive behavioural therapies, family and marital treatment and even psychiatric hospitalization may be indicated before medications are used.

An antipsychotic drug of choice might be haldoperidol in lowest

possible divided dosages and avoided in the first three months of pregnancy.

Antidepressant drugs are not safe in pregnancy and lactation.

Lithium and Carbamazine should be avoided because of their teratogenic effects. The patients should be warned of their possible harm, if they are being used and those patients should be carefully monitored.

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