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Perinatal Psychiatry in Context to Women 'S Health

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Abstract

Introduction: Women's Mental Health Traditionally focuses on women's reproductive health,like Puberty, Pregnancy, Menopause now it is expanding to include disorders and conditions more prevalent in females than in males, or different in clinical features and risk factors. Perinatal Psychiatry refers to mental health issues in antenatal and postpartum period like Antenatal depression, Postnatal blues, Postpartum depression, Postpartum psychosis.

Methods: The global burden of psychiatric disorders in women is increasing, especially in the perinatal period. We have focused on discussing the impact of culture on the perinatal psychiatric disorders and management principles of different perinatal psychiatric disorders. Health-care delivery in the perinatal group of population has been improving over the years, but still there is lot to improve.

Conclusion: A scientific and evidence-based approach is a definite need toward attaining this goal.

***Key Words**: Perinatal Psychiatry; post partum blue; postpartum psychosis; post partum depression; Mental health.*

Introduction

Perinatal Mental Health

Women's Mental Health Traditionally focuses on women's reproductive health, eg: Puberty, Pregnancy, Menopause now it is Expanding to include disorders and conditions more prevalent in females than in males, or different in clinical features and risk factors. Perinatal mental health has become a significant focus of interest in recent years.

Psychiatric disorders in India contribute to about 11.6% of the global burden of disease (GBD) (WHO, 2008) and have the highest number of suicides in the world. The lifetime prevalence of any form of mental illness in Indian population is 13.7%.[1] The GBD of mental disorders among women aged between 15 and 44 years is 7%.[2] In Indian women and teenage girls aged 15–19 years, suicide has surpassed maternal mortality as the leading cause of death.[3]Despite an increase in the age of marriage, 61% of all women (69% in rural regions and 31% in urban areas) are married before the age of 16 and the median age at first pregnancy is 19.2 years.[4,5] As evident from the statistics, this particular age group as such is vulnerable to mental morbidity which becomes more problematic when combined with the phenomenon of pregnancy. Hence, mental health of perinatal women is the need of the hour.

Culture, and Perinatal Mental Health

Gender is a critical determinant of mental health and mental illness. In the Indian culture, several factors determine the mental health of women like joint family system, patriarchy, marriage a must, preference for the male child, practice of dowry, , strict code of conduct for females, lower educational status of women and primary

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roles of women being childbearing and child-rearing.[6,7] In India, events related to pregnancy are perceived as "normal phenomena" and usually medical help is sought at times of emergencies or crisis,[8] thus leaving minimal role for preventive measures. Sometimes, adversities are believed to be a part of pregnancy, wherein a fatalistic attitude of any sort of medical help would yield no beneficial changes, is common.[9]Any ill health is less explained on the lines of modern medicine and more in terms of religious faiths and curses or fate.[8]

Cultural attitudes and stigma significantly affect the mental health of the mother. Rituals are usually a routine phenomenon wherein special diets, massage, warm environment, and traditional healing foods are offered to the mother and many times the extended family members are given the responsibility of taking care of the infant. Modern medicine practices appear to be out of the norm and considered to be non-Indian, which cause conflicts between the mother and her extended family and may hinder the social support. However, gradually, modern medicine has been adopted by educated people.[10] According to Hema et al., 2008, in India, incorporation of postpartum depression (PPD) into maternal child health services has been a new initiative overcoming the various cultural issues and stigma associated with the treatment.[11]

Post partum psychiatric disorder

Postpartum period is demanding period characterized by over whelming biological, physical, social, and emotional changes. It requires significant personal and interpersonal adaptation, especially in case of primigravida. Many females experience a wide range of overwhelming emotions such as anticipation, excitement, happiness, fulfilment, as well as anxiety, frustration, confusion, or sadness/guilt during pregnancy and postpartum period. The postpartum period makes them highly vulnerable to various psychiatric disorders. Traditionally postpartum psychiatric disorders are classified as maternity blues, puerperal psychosis, and postnatal depression. Postpartum psychiatric disorders can adversely affect mother-infant interaction and attachment. Hence, early diagnosis and management of the postpartum psychiatric disorder is extremely crucial.[12]

Postpartum blues(PB)

PBs, also known as "baby blues" or "maternity blues," is a phase of emotional lability following childbirth. Most of these women report symptoms consistent with "baby blues," a transient mood disturbance characterized by mood !ability, sadness, dysphoria, subjective confusion, and tearfulness. The symptoms arise within the first 10 days and peak around 3–5 days. Generally symptoms of PB do not interfere with the social and occupational functioning of women. PBs persisting for more than 2 weeks may make women vulnerable to a more severe form of mood disorders[12].

Postpartum depression

As per Rai et al.,[13] about 10%–15% of postpartum women have PPD, making it the most common disorder in postpartum women. PPD can occur during pregnancy or within the first 12 months following delivery.PPD is generally difficult to distinguish from depression occurring at any other time in a women's life. In PPD the negative thoughts are mainly related to the newborn. It is seen in 10–15% of postpartum women and, in addition to postpartum time specifier, the diagnostic criteria is difficult to differentiate from that of major depressive episode characterized by pervasive depressed mood, disturbances of sleep and appetite, low energy, anxiety, and suicidal ideation. Additionally feelings of guilt or inadequacy about the new mother's ability to care for the infant, and a preoccupation with the infant's well-being or safety severe enough to be considered obsessional.

Postpartum psychosis(PP)

Postpartum psychosis (sometimes called puerperal psychosis) is an example of a psychotic disorder that occurs in women who have recently delivered a baby. Acute and abrupt onset, usually observed within the first 2 weeks following delivery or, at most, within 3 months postpartum, and should be regarded as a psychiatric and obstetrical emergency The syndrome is often characterized by the mother's depression, delusions, and thoughts of harming either herself or her infant. Such ideation of suicide or infanticide must be carefully monitor. At times, delusions revolves around the infant, especially that the infant is possessed, has special powers, is divine, or is dead. Infanticide and suicide are observed in 4% and 5% of the women suffering

from PP respectively. Enquiring about suicidal and infanticidal thoughts is crucial during the assessment of women suffering from PP. Past history of psychosis with previous pregnancies, history of bipolar disorder, family history of psychotic illness (e.g., schizophrenia or bipolar disorder) are some of the major risk factors for the development of PP. although rare, some mothers have acted on these ideas. The symptoms of postpartum psychosis can often begin within days of the delivery, although the mean time to onset is within 2 to 3 weeks and almost always within 8 weeks of delivery[12].

Bipolar disorder

Bipolar disorder is a major risk factor for PP. The women are at a high risk for relapse during and after pregnancy, being about 3 times more compared to non pregnant women who are not on mood stabilizers and being euthymic at the time of conception. The majority of episodes were depressive or dysphoric and seen during the first trimester. Perinatal bipolar disorder diagnosis takes a back step when any patient presents with depression, which is further complicated by insomnia, poor mother–infant interaction, and obsessions regarding the baby, delusions, suicide, etc.[12]

Postpartum posttraumatic stress disorder

Many studies have shown the incidence of postpartum PTSD to be around 5.6%. It is generally characterized by tension, nightmares, flashbacks and autonomic hyper arousal that can continue for some weeks or months, and may recur toward the end of the next pregnancy. This can also result in secondary tocophobia.[12]

Anxiety disorders specific to the puerperium

The most common feature is nocturnal vigilance characterized by the mother lying awake listening to the infant's breathing, and frequent checking resulting in sleep deprivation. Many mothers are excessively worried and preoccupied about the health and safety of their children which is known as "maternity neurosis."[12]

Obsessions of child harm

Women diagnosed with postpartum onset of major depression may have repetitive, intrusive thoughts related to some occurring to the baby associated with compulsive checking behaviour. Postpartum onset of OCD can occur during gestation or within 6 weeks following delivery. The theme of the obsessions is frequently related to thoughts/gruesome images of harming the baby.[12]

General principles of management

Detailed documentation regarding the women's menstrual history, informed consent decision regarding the conception and medications, treatment recommendations, consistent monitoring of patients for adequate therapeutic control and preventing toxicity, addressing psychosocial factors, and encouraging to normalize daily activities such as sleep hygiene and healthy lifestyle modifications.

Nonpharmacological treatment

Educating the patient and family members about the nature of treatment definitely helps in handling the responsibilities of motherhood better. Individual, interpersonal, group psychotherapy, reassurance, psychoeducation, and emotional support have shown to improve social adjustment in mothers.[14-]

Pharmacological treatment

Medication management during pregnancy and lactation gets complicated by concerns about teratogenicity (congenital malformations), neonatal complications, and by pharmacodynamic or pharmacokinetic interactions of the drugs. Electroconvulsive therapy is another therapeutic option for severely ill patients but does not replace pharmacotherapy. In premature infants, breastfeeding can be avoided if the mother is on psychotropic medication. Breastfeeding can be done at times when the breast milk drug concentration is lowest, like just before or after taking medication.[14]

Breastfeeding

Women may be suggested to avoid breastfeeding as this may cause sleep deprivation, which may precipitate disturbances in mood, also that all psychotropic drugs are excreted in breast milk at various concentrations. However, in view of the infant's health demand, breastfeeding can be followed.

Management of individual disorders

Postpartum blues

They usually do not cause dysfunction and are self-limiting with no requirement for active intervention except social support from the family members[13].

Postpartum depression

PPD responds to similar treatment interventions as depression at other times, with few exceptions in the guidelines for this special population. Selective serotonin reuptake inhibitors (SSRIs) are recommended as the first-line therapy in PPD, for postpartum dysthymia, panic disorder, and obsessive-compulsive disorder[14].

In women with bipolar disorder

During pregnancy

Antidepressants should generally be avoided. In women already taking antidepressants, decision regarding continuation of the drugs should be judged on clinical, pharmacological, and social support profile of the patient. Abrupt withdrawal of the antidepressants may precipitate emergence of (hypo) manic or psychotic symptoms, wherein the use of psychotropic medications such as olanzapine, quetiapine or mood stabilizers may be indicated .

Post delivery

Antidepressants need to be used with caution and best be avoided[14].

Perinatal health-care system

Some of the initiatives taken by the government are:

1. As per the Health Care For All initiative under the Ministry of Health and Family Welfare, there is a 27.7% increase in the budget allocation for health care sector from Rs. 37,061.55 crores in 2016–2017 to Rs. 47,352.51 crores in 2017–2018

2. In the National Health Mission, for 7498 renovations of health facilities, 43,726 ASHA workers were selected

3. Mission Parivar Vikas was launched for effective family planning, aiming to provide services and contraceptives to nearly 146 districts of 7 high-focus states in North India; in which nearly 30 lakh postpartum intrauterine device insertions were done from 2014 to February 2017

4. Janani Suraksha Yojana and Janani Shishu Suraksha Karyakram aimed at minimizing maternal and neonatal mortality ratios

5. In Mental Health Care Act 2017, a special clause for women and children regarding admission and treatment has been emphasised

6. The Constitution included a special provision in Article 15, permitting the state to positively discriminate in favour of women by enacting laws/provisions so as to ameliorate their social, economic, and political condition and to accord them parity

7. In the premiere institutions such as AIIMS (New Delhi), NIMHANS (Bengaluru), and others, provisions have been made for postdoctoral fellowship courses.

Conclusion

Provision of standardized and operationalized criteria for identification, diagnosis, referral, management, and follow-up of perinatal psychiatry disorders is needed. Improvement has been done at. Various levels political and policy level, medical and nonmedical level, and social and family. Better integration of perinatal health care at all these levels would be warranted for a holistic care of women in India.

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