PUERPERAL PSYCHIATRIC DISORDERS - WHO CARES?

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"If we come to think of it, every child that is begotten and born, is a seed of change, a danger to its mother, at childbirth great pain and after birth a new responsibility, anew change" (D.H. Lawrence). Add to this that eighteen times as many women are admitted to mental hospitals in the first month postpartum as in each month of pregnancy[1]. One can easily appreciate that the happy event of childbirth is not always a source of unalloyed joy. The puerperium has been known to be the most vulnerable period in a woman's emotional life since the time of Hippocrates, who described a woman becoming restless and later delirious following the birth of twins[2]. This condition first described in detail as postpartum psychosis, though very obvious due to its dramatic presentation is not much common. Far more common are two other conditions, the maternity blues[3] and postnatal depression[4]. Awareness about these conditions and their deleterious effects on mother and baby has developed only over the last three decades. In developing countries, including our own, where mental health is amongst the lowest priorities, the psychiatric aspect of puerperium still remains largely neglected. The price in terms of physical and mental health of the baby and the mother is high and we can no longer afford to neglect it. Although their specificity to the postpartum period has recently been questioned[5], the maternity blues are known to occur in more than half of the mothers. Symptoms include crying spells, sadness, lability of mood, irritability, confusion or forgetfulness, insomnia and anxious feelings often related to convictions of maternal incompetence[3]. The symptoms generally peak between the third and seventh postpartum day[6]. The condition is transitory and no treatment other than reassurance and support is required. The next condition on the spectrum of severity is postnatal depression. Except one recent methodologically sound study[7], almost all the investigators including those who used strict diagnostic criteria[8,9], have found the incidence of this disorder to be 8-15%. We should not have a false sense of security by being under the impression that the better family support will have protective effect as similar rates of postnatal depression have been found in African population[10]. Anxiety often related to the baby's health, irritability, easy fatiguability, variable insomnia, suicidal thoughts or fear of harming the baby are common symptoms. In our setting such symptoms may be disguised as excessive concern about a physical illness which may be attributed to affliction with the 'Wind" on not observing postpartum rituals. The patient may not admit depressed mood, though tears and other depressive behaviour may at times be apparent. The family on the other hand may be concerned about her increased irritability and rather casual attitude towards the baby. The puerperal psychosis is not a specific diagnostic entity in the present classificatory systems. These are thought to be affective, schizophrenic or organic psychosis which simply happen to be precipitated after childbirth. Nevertheless, the term if not the concept is tenacious and carries special meaning for many clinicians. Although the time limit varies, it usually implies a psychotic disorder arising within 90 days of childbirth characterized by insomnia, confusion, perplexity, visual hallucinations, lability of mood, prominent delusions in depressed mood and morbid ideas relating to the baby and unexpected rejection of the newborn[11]. With an incidence of approximately one in 500 deliveries in Western studies this is thought to be an uncommon condition; but this appears to be an underestimate, as organic psychoses occur very commonly in developing countries due to higher incidence of physical complications of puerperium, i.e., upto 37% in one African study[12] compared to almost none in studies from developed countries. Even based on this incidence, high fertility rate of 6. 4[13] in our country means a higher rate for our female population, particularly so when the risk of further puerperal relapses is increased 100-

fold after the first one[14]. These psychiatric disorders have serious implications for the relationships of mother with the newborn in particular and for other interpersonal relationships in general, which seems to be the major reason for recent surge in interest in this field. Postnatal depression has been demonstrated to have adverse effects on the intellectual and emotional development of the younger children in many well executed studies[15-17]. On the other hand infanticide has been reported in upto 4% of cases with puerperal psychosis[18]. Makanjoula[19], in his study in Nigerian population, found that seven babies died and other seven became severely ill as a result of malnutrition and gastroenteritis due to lack of maternal care after the onset of a postpartum psychotic disorder. Similarly definite loss of sexual relations, and deterioration in her personal appearance, doubts about future sanity of the wife reinforced by the popular notions about mental illness and practical problems in seeking treatment of these disorders can all combine to cause worsening of marital relationships and even worse, desertion[19]. If one out of ten women becomes depressed and one out of 500 is afflicted with a psychotic disorder following childbirth with such a serious consequence, we have not much reasons for complacency. The treatment and prevention of postnatal psychiatric disorders should therefore, become a major public health concern.

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