

## Review Article

# Post Partum Mood Disorders and Management

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### Abstract

Suicide and deliberate self-harm during pregnancy is becoming an emerging problem in globally. Due to changes of the hormonal levels, lack of support at home and previous mental well-being issues would contribute for the bad outcomes during pregnancy. Pregnancy and the puerperium are at times sufficiently stressful to provoke mental illness. Such illness may represent recurrence or exacerbation of a preexisting psychiatric disorder, or may signal the onset of a new disorder. In developed countries suicide is a leading cause of maternal death.

Post partum mood disorders are classified in to several categories based on the DSM-IV classification. Post partum blues is the commonest cause (85%). Puerperal psychosis is rare (0.1%), however, it is an psychiatric emergency. Electroconvulsive therapy is safe in pregnancy. Patient who need inward care better to admit to special mother and baby care units. Psychiatric disorders during pregnancy have been associated with poor prenatal care, substance abuse, poor obstetrical and infant outcomes, chronic mental health problems.

**Keywords:** Post partum mood disorders

### 1. Introduction

This review article focus on post partum mood disorders and the importance of management of those

conditions. This have been associated with poor obstetrics out come, substance abuse and long term psychiatric illness. Mild psychological and transient mood disorders are very common in post partum period [1, 2, 3]. In Sri Lanka maternal deaths due to suicide has been increased from 2002 to 2010 [4]. Currently, suicide is a leading cause of maternal death in UK and USA [5, 6].

According to International Classification of Diseases (ICD-10) and Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV), post partum mood disorders are categories into several groups [7, 8]. In this article we would discussed, post partum blues, post partum depression, post partum psychosis, anxiety disorders, eating disorder and schizophrenia spectrum disorders in pregnancy. Comparison of the main disorders are summarize in the Table 1. Post partum period would begin immediately after child birth and six weeks following that, and hormonal changes, personality issues, family support and previous existing mental disorders would lead to post partum mood problems.

### **1.1 Postpartum blues (Baby blues, Maternal blues)**

This is a very common condition begins immediately after birth and can lasts for two weeks. The peak of symptoms develops on day four or five. Nearly 50-85% of the new born women are suffer with this condition. Most characterized features are the mood swings and tearfulness. Further, exaggerated the emotional state, irritability, anxiety, insomnia, loose of appetite, fatigability and poor concentration can be found. Usually, patient become very tearful for few hours and become well, and again they develop the similar symptoms in the following day [9].

The cause for this condition is not fully understood, however, lack of sleep, poor social and family support, financial stress, marital issues and unrealistic expectation are the main contributing factors. Abrupt changes of hormonal level after delivery could be another explanation. There were several studies to assess the prolactin, progesterone, allopregnanolone, tryptophane, cortisol level which relation to post partum blues. However, there was no conclusive evidence. Despite being a common condition still there are no well- established diagnostic criteria or rating scale.

**1.1.1 Treatment and follow up:** This is a self-limiting condition therefore; sleep and supporting care would be the best. Advice on avoids alcohol consumption and smoking. Most of the patients would resolve the issue in few weeks and those who with persistent symptoms are at risk of progress to post partum depression and psychosis. However it is an independent risk factor for development of post partum depression. O'Hara et al reported that 20 % of women with post partum blues would develop post partum depression [10].

	<b>Post partum Blues</b>	<b>Post partum Depression</b>	<b>Puerperal Psychosis</b>
Incidence	50 – 85 %	1-10%	0.1%
Onset	Day 4 or 5 following delivery	After 2weeks to 2 months following delivery	Usually two weeks after delivery
Course of the disease	Self limiting	Can progress up to years	Can progress up to years
Associated factors	Change from very tearful to later became well, Irritable, Anxiety	Severe exhaustion mood swings, irritability, low energy, low libido	Delusion, hallucination, confusion, bewilderment
Risk factors	Lack of sleep , Poor family support	Teenage , Single parent , Poor family support	Personal or family history of Depression
Treatment options	Supportive care	Anti depressive medications Mood stabilizers	Antipsychotic medication Electroconvulsive therapy
Prognosis	Usually good, recurrence is very common.	Varies	Varies 50% of recurrence

**Table 1:** Comparison of each mood disorders in a single file.

## **2. Post Partum Depression**

This condition can affect to 1-10% of women after delivery. Usually it starts after two weeks to two months after delivery specially those who suffered from postpartum blues. The risk group are the teenage mother, single parent, poor family and social support, low self esteem, history of birth related trauma, child hood experience of abuse, family history of depression and smoking. The exact etiology is still unclear. Changes of the hormonal pattern of the body would be the main cause such as sudden decline of progesterone and estrogen hormone levels. Numerous studies on potential psychosocial risk factors for post partum depression gives no clear consensus. The demographic variables such as age, education level, and marital status not associated with disease entity [11]. Common symptoms are the severe exhaustion, mood swings, irritability, low energy, low libido, insomnia, social withdrawal and lack of concentration. The Edinburgh Postnatal Depression Score is a self-report scale that has ten items related to symptoms of depression through which patients can easily identified.

### **2.1 Treatment and follow up**

The management should include the social support and antidepressants. Psychiatrist involvement is essential and patients required hospitalization, which has mother and baby care units. National institute for clinical excellence (NICE) has recommended that women with mild to moderate depression offer cognitive-behavioral therapy and interpersonal psychotherapy as first line methods [3, 12]. Antidepressant medication would use for resistant cases and severe disease category. Evidence suggests selective serotonin reuptake inhibitors (SSRI) are the effective treatment. Frist line drug would be Sertraline. Most of the antidepressants are excreted in breast milk and generally safe during breast-feeding. The comparison of medication are summarize in Table 2.

In extreme cases electroconvulsive therapy showed more beneficial. Cognitive and behavioral therapy help to improve the symptoms much earlier. The use of hormonal treatment would be doubt [13]. Systemic analysis report suggest that high dose of estrogen did appear to reduce the depression score, however associated with deep vein thrombosis, endometrial hyperplasia and endometrial cancers. Progesterone showed no benefit.

<b>Medication Type</b>	<b>Effect on pregnancy</b>	<b>Fetal effects</b>	<b>Lactation</b>	<b>Pre conception</b>
Selective Serotonin Reuptake Inhibitors (SSRI) Eg-Fluoxetine Sertraline	Need to increase the dose	Cardiac defects Omphalocele (2/1000)	Present in breast milk (Sertraline is the Drug of choice)	Need change to drugs with lowest side effect.
Tri Cyclic Anti Depressant (TCA)	Needs to increase dose	Fetal growth restriction	Consider safe	Consider safe
Lithium	Reduce the dose during and before delivery.	Cardiac defects Neonatal arrhythmias Hypoglycemia Thyroid dysfunctions	Present in breast milk Slow clearance from neonatal body	Not safe
Diazepam	Should not stop abruptly	Neonatal withdrawal Symptoms Cleft lip and cleft palate Cardiac defects Respiratory depression.	Present in breast milk Sedation Lethargy (Better avoid)	Not safe (Only for short term use)
Electro Convulsive Therapy (ECT)	Safe during pregnancy	No effect	Safe	Safe

**Table 2:** Medications used to treatment of mood disorders in pregnancy.

### 3. Post Partum Psychosis

Studies estimate the incidence of 1-2 per 1000 births and it can be even higher [14]. It showed clear association between bipolar disorder and puerperal psychosis. Usually it appears after two weeks of delivery, however, it may occur even in first few days as well. The most important risk factors would be the bipolar affective disease. It could be familial. Obstetrics risk factors would be the primip, carrying a female baby, preterm delivery, family history, caesarean delivery, and complications during delivery. There were studies going on basis of hormonal effects on puerperal psychosis, however, it remains circumstantial. Lack of sleep and fatigability can be a trigger factor [15, 16]. Women with bipolar affective disorders need to switch off from Lithium before pregnancy. At least half of the population does not have any risk factors. It characterized by combination of mania and depression, severe anxiety, suicidal thoughts, deliberate self harm and injure to the baby. Symptoms can be varying from mood symptoms such as elation and depressive ideas, confusion, bewilderment to psychotic symptoms such as delusion and hallucination.

### **3.1 Treatment and follow up**

This is a psychiatric emergency. The principles of management are hospitalized; pharmacological treatment and long term psychiatric follow up. It advice that keep in special mother and baby care unit. Need to start on antipsychotic medication and mood stabilizers. Lithium is usually avoiding as it cause the toxicity to baby. It has 50 % chance of recurrence in future pregnancies [17].

## **4. Other Disorders**

### **4.1 Anxiety disorders**

This can be includes panic attacks, specific phobias, social anxiety disorders or generalized anxiety disorders. Symptoms would be the fear, nausea, dizziness, lack of sleep, frequency of urination and tension features. These can be treated with SSRIs, TCAs, Monoamine oxide inhibitors and anxiolytics.

### **4.2 Eating disorders**

Mainly confined to adolescents and present with either anorexia nervosa or bulimia nervosa. Prevalence is around 3- 5 percent. In anorexia nervosa, patients present with refuses to eating, prolonged fasting, retching and vomiting. Binge eating habits followed by fasting are common among patient with bulimia nervosa. They manage with cognitive and behavioral therapy.

### **4.3 Personality disorders**

Patients can be paranoid, schizotypal personality disorders, antisocial behavior, avoidant or fear and anxiety.

## **5. Conclusion**

Pregnancy and puerperium are very stressful periods and itself can provoke the mental illness. This can leads to adverse maternal and fetal outcomes such as deliberate self-harm, suicide, neglect the child or infanticide. Therefore, it need prompt actions to control the condition.

## **Conflicts of Interest**

There are no conflicts of interest.

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