Psychological disturbances in obstetrics *(Part I)*

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Introduction

Pregnancy is a time of joy, contentment and emotional wellbeing and is a landmark event for women that generate physical, emotional and social changes. However, there is evidence that pregnancy does not protect women from mental illness. Psychiatric disorders especially mood and anxiety disorders have the highest incidence in women in the child bearing years. Furthermore, these disorders can occur during pregnancy or during the postpartum period.

This article begins by examining the importance of psychological disturbances in pregnancy and why this needs to be recognised. This is followed by an account of psychiatric disorders in pregnancy and their management. Finally the article describes post-partum psychiatric disorders and their management.

Why is it important to address psychological disturbances in pregnancy?

Psychiatric problems in pregnancy can lead to reduced antenatal care, and lack of proper care of the mother leading to problems in the unborn baby. To compound this, there is a risk of increased substance use (alcohol, cigarettes and illicit drugs) and impulsive behaviours which are harmful to the unborn baby.

Psychiatric illness contributes to maternal mortality. The recent UK Report 'Why mothers die 2000-2002' identified psychiatric illness as the leading cause of maternal death in the UK. Therefore it is important to identify psychiatric illness and treat it appropriately during pregnancy.

During pregnancy, symptoms of psychiatric disorders such as disturbed sleep, appetite and changed energy levels and interest levels can be associated as symptoms of pregnancy and psychiatric illness may be missed out and not adequately managed due to this. Considering all these factors, it is important to identify and treat psychiatric disturbance that occurs during pregnancy.

Pregnancy and psychological disturbance

Pregnant women undergo many psychological changes. Their attitudes towards pregnancy reflect beliefs about all aspects of reproduction, including if the pregnancy was planned and if the child is wanted. The women's age, her relationship with her husband and her sense of identity affect her reaction to prospective motherhood. Healthy women find pregnancy a means of self-realization[1].

Psychological attachment to the foetus begins in utero and most women have a mental picture of the infant by the start of the second trimester. Recent research has shown that mothers who talk to their unborn child develop an early infant-mother bond and this also increases the mother's efforts to have a healthy pregnancy (a healthy lifestyle during pregnancy).

Certain conditions that occur during pregnancy such as hyperemesis gravidarum, spontaneous miscarriage and stillbirth may be associated with psychological disturbance and these effects are described next.

Hyperemesis gravidarum

Some authors have suggested that vomiting in the first trimester and hyperemesis gravidarum are of psychological aetiology, but this has not been established. However, it is possible that psychological factors affect the severity and course of these symptoms[2].

Spontaneous miscarriage

Approximately a fifth of diagnosed pregnancies do not progress beyond 20 weeks. After a spontaneous miscarriage many women show features of typical grief such feelings of sadness, preoccupation with thoughts of the baby, tearfulness, irritability, insomnia, difficulty concentrating and doing daily activities. This is similar to the mourning process that occurs when a loved one is lost. Some women develop depressive symptoms and this is more common in women with a

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past history of a spontaneous miscarriage. Most symptoms improve with time[2]. Second trimester miscarriages are more traumatic than first trimester miscarriages possibly because the mother has already formed a bond with the baby.

Antenatal death

Stillbirth or antenatal death can cause an acute bereavement reaction which is similar to the grief reaction that occurs in spontaneous miscarriage (mentioned above). However, some women develop long term psychiatric problems following an antenatal death. The parents should be helped to mourn by encouraging them to see and hold the baby, to name the baby and have a funeral for the baby. They would need support after the funeral and the next pregnancy will be a particularly stressful time[2]. However, there is some evidence from current research that states that contact with the dead baby may not help the mourning process but add to the psychological distress[3]. Therefore this decision to view and handle the dead baby needs careful consideration taking the viewpoint of the parents.

Psychiatric disorders in pregnancy

Some women can experience psychiatric symptoms for the first time during pregnancy, while some others may be on treatment for a psychiatric disorder when they become pregnant. Psychiatric symptoms in pregnancy are more common in women who have had a past history of psychiatric illness and those with serious medical problems that complicate the pregnancy (e.g. diabetes). Furthermore, the psychiatric disturbances that occur in pregnancy are more common in the first and third trimesters of pregnancy. Depression, anxiety, bipolar disorder and psychosis are some of the psychiatric disorders that may be present during pregnancy.

Depression in pregnancy

One fifth of pregnant women experience major or minor depression[4]. Discontinuation of antidepressants in pregnancy can precipitate a relapse of depressive symptoms in those women who are already on treatment for depression[5].

It is sometimes difficult to distinguish between the symptoms of depression and those that occur in pregnancy. The symptoms of depression are low mood, reduced energy, disturbed sleep, reduced appetite, loss of interest and enjoyment, reduced concentration, low self esteem and self confidence, ideas of guilt and unworthiness, and suicidal thoughts. Low mood occurs in pregnancy too. However, the low mood in pregnancy is not sustained during the day like that in depression. Also there is no loss of pleasure during pregnancy whereas a depressed person has no pleasure. Furthermore, fatigue in pregnancy responds to rest while fatigue in depression does not. Appetite improves as pregnancy progresses but if loss of appetite is part of depression it does not improve with progression of the pregnancy. In this way the symptoms of depression can be differentiated from those of the pregnancy.

There are characteristics that can predict occurrence of depression in pregnancy. An increased risk for depression in pregnant women include a history of depression, younger age, limited social support, marital conflict, greater number of children, ambivalence about the pregnancy, substance abuse, poor nutrition, barriers to care and unstable housing[6]. The presence of these factors should prompt the clinical to be vigilant for emerging depressive features.

Depression has adverse effects on pregnancy. Uncontrolled maternal depression puts, the unborn baby at risk due to poor perinatal care, substance abuse and suicidal attempts[7]. Apart from this it may cause relationship problems and inability to care for other children and loss of employment. Mood disturbance has been associated with poor obstetric outcomes too. For example, it has been associated with altered fetoplacental function, premature delivery, impaired foetal growth, perinatal complications and possible long-term childhood behavioural problems[5,8,9]. Moreover, foetal heart rate reactivity has been shown to be delayed in untreated maternal depression[10].

Many women in whom post natal depression has been diagnosed have had the onset of their symptoms during the antenatal period[11]. Therefore increasing depressive symptoms during pregnancy are important and need assessment.

The treatment of depression during pregnancy is with antidepressants if psychological management fails. Please see the section on 'Psychopharmacologic treatment in pregnancy' for a description of the antidepressants used in pregnancy. Electroconvulsive therapy (ECT) can be used to treat severe depression.

Anxiety in pregnancy

Anxiety may be a normal symptom experienced during pregnancy. Mothers may experience anxiety on their adequacy as a parent, or be ambivalent about the addition of a child to the family. However, an anxiety disorder is only diagnosed if the anxiety levels are high and impair daily functioning.

Normal pregnancy symptoms must be distinguished from anxiety because in pregnancy the heart rate increases, sweating increases and nausea occurs, and some hot or cold flushes may be noted. The way to distinguish the difference is that although pregnant women are anxious about their health and that of the baby, they are not anxious about all other concerns as are patients with anxiety disorders.

Panic disorder, generalised anxiety disorder and obsessive compulsive disorder are some of the anxiety disorders experienced during pregnancy. Generalised anxiety disorder is characterised by worry and apprehension, muscle tension, autonomic over-activity, and sleep disturbance. In panic disorder there are panic attacks which are sudden attacks of anxiety in which physical symptoms predominate. The anxiety builds up quickly. The symptoms are shortness of breath, choking, palpitations and increased heart rate, chest discomfort or pain, sweating, dizziness, nausea, abdominal distress, numbness/tingling, flushing, trembling or shaking, tinnitus and fear of dying.

Obsessive compulsive disorder is where there are repetitive thoughts, obsessive doubts (locking doors, turning off lights), impulses or images, and compulsive rituals (checking, cleaning, washing, counting in a special way). The patients struggle to resist these obsessive thoughts which intrude on them. Obsessive compulsive disorder may be precipitated or worsen during pregnancy.

These anxiety disorders are frequently accompanied by depressive symptoms. Cognitive behavioural therapy is a recognised treatment for all anxiety disorders in pregnancy.

Bipolar disorder in pregnancy

Bipolar disorder is difficult to manage during pregnancy due to the high chance of relapse and teratogenicity associated with mood stabilizers used to manage this condition. Research indicates that an abrupt cessation of maintenance treatment (mood stabilizers) is a risk factor for symptom exacerbation. Ideally women with bipolar disorder need to obtain a psychiatric assessment before conception to have a trial of tapering medication before pregnancy. Bipolar disorder needs to be managed in collaboration with a psychiatrist due to these complications associated with relapse and treatment in pregnancy.

References

1. Sadock BJ, Sadock VA. Psychiatry and reproductive medicine. In Kaplan and Sadock's Synopsis of Psychiatry. 10th ed. 2007, New York: Wolters Kluwer/Lippincott Williams & Wilkins.
2. Gelder M, Harrison P, Cowen P. Psychiatric aspects of medical procedures and conditions. In Shorter Oxford Textbook of Psychiatry, 2006, Oxford: Oxford University Press.
3. Hughes P, Riches S. Psychological aspects of perinatal loss. *Current Opinion in Obstetrics and Gynaecology* 2003; **15**: 107-11.
4. Gotleib IH, Whiffen VE, Mount JH, Milne K, Cordy NL. Prevalence rates and demographic characteristics associated with depression in pregnancy and the postpartum. *Journal of Consulting Clinical Psychology* 1989; **57**: 269-74.
5. Nonacs R, Cohen LS. Deprression during pregnancy: diagnosis and treatment options. *Journal of Clinical Psychiatry* 2002; **63**(Suppl 7): 24-30.
6. Altshuler LL, Hendrick V, Cohen LS. Course of mood and anxiety disorders during pregnancy and the post partum period. *Journal of Clinical Psychiatry* 1998; **59**(Suppl. 2): 29-33.
7. Zuckerman B, Amaro H, Bauchner H, Cabral H. Depressive symptoms during pregnancy: relationship to poor health behaviours. *American Journal of Obstetrics and Gynaecology* 1989; **60**: 1107-11.
8. Lumley J, Austin M. What interventions may reduce postpartum depression. *Current Opinion in Obstetrics and Gynaecology* 2001; **13**: 605-11.
9. Orr ST, Miller CA. Maternal depressive symptoms and the risk of poor pregnancy outcome. *Epidemiology Review* 1995; **17**: 165-71.
10. Allister L, Lester BM, Carr S, Liu J. The effects of maternal depression on fetal heart response to vibroacoustic stimulation. *Developmental Neuropsychology* 2001; **20**(3): 639-51.
11. Tam WH, Cheung T. Psychosomatic disorders in pregnancy. *Current Opinion in Obstetrics and Gynaecology* 2007; **19**: 126-32.
12. Cott AD, Wisner KL. Psychiatric disorders during pregnancy. *International Review of Psychiatry* 2003; **15**: 217-30.
13. Zisook S, Burt V K. Psychiatric disorders during pregnancy. *Psychiatric Times* 2003; **20**(1):
14. Maudsley Prescribing Guidelines 2007-2008. The South *London and Maudsley Trust.* pp. 268-82.
15. Sadock B, Sadock VA. Psychiatry and reproductive medicine. In Kaplan and Sadock's Concise Textbook of Clinical Psychiatry. 3rd ed. 2008, New York: Wolters Kluwer / Lippincott Williams & Wilkins.
16. Cox JI, Murray D, Chapman G. A controlled study on the onset, duration and prevalence of postnatal depression. *British Journal of Psychiatry* 1993; **163**: 27-31.
17. Shaw E, Kaczorowski J. Postpartum care - what's new? *Current Opinion in Obstetrics and Gynaecology* 2007; **19**: 561-7.