PUERPERIUM/PUERPERAL
PSYCHOLOGICAL ASPECTS

Done by: Thaer Omar Al-Qatish
Postpartum period

• The postpartum period refers to the six- to eight-week period after the birth of a baby in which the body recovers from the changes caused by pregnancy and birth.
Postpartum Psychological changes

• During this period of physiological change, the mother is also vulnerable to psychological disturbances.

• Adequate understanding and support from her partner and family are crucial.
Postpartum Psychological changes

• Although the incidence of mild mental health problems is not significantly different during pregnancy, the risk of bipolar or severe depressive illness is greatly increased postpartum and this period represents perhaps the highest risk period in a woman’s life for the development of a psychiatric disorder.

• Women with previous serious mental health problems are at higher risk.
Postpartum Psychological changes

• Hormones

• Stress

• Body changes and body image

• Fatigue
Postpartum Psychological changes

• During the postpartum period, about 85% of women experience some type of mood disturbance. For most the symptoms are mild and short-lived.

• 10 to 15% of women develop more significant symptoms of depression or anxiety.

• Postpartum psychiatric illness is typically divided into three categories:
  • (1) postpartum blues
  • (2) postpartum depression
  • (3) postpartum psychosis.
Normal Postpartum Emotional Changes

• 1) The ‘pinks’: for the first 24–48 hours following delivery, it is very common for women to experience an elevation of mood, a feeling of excitement, some overactivity and difficulty sleeping.

• 2) The ‘blues’: as many as 80% of women may experience the ‘postnatal blues’ in the first 2 weeks after delivery. Fatigue, short temper, difficulty sleeping, depressed mood and tearfulness are common but usually mild, and resolve spontaneously in the majority of cases.
Alarming changes that require interventions

1) panic attacks
2) episodes of low mood of prolonged duration (>2 weeks)
3) low self-esteem
4) guilt or hopelessness
5) thoughts of self-harm or suicide
6) any mood changes that disrupt normal social functioning; ‘biological’ symptoms (e.g. poor appetite, early wakening)
7) change in ‘affect
Pathophysiology of Postpartum Mood Disorders

1) Changes in cortisol, oxytocin, endorphins, thyroxine, progesterone and oestrogen have all been implicated in the causation.

2) A recent theory is that the sudden fall in oestrogen postpartum triggers a hypersensitivity of certain dopamine receptors in a predisposed group of women and may be responsible for the severe mood disturbance that follows.

3) The occurrence and the severity of the ‘postnatal blues’ are thought to be related to both the absolute level of progesterone and the relative drop from a prepartum level. However, there is no clear association between the ‘postpartum blues’ and affective psychoses, and no evidence as yet to implicate progesterone in the aetiology of puerperal psychosis or severe postnatal depression.
Screening questions for mental health during and after pregnancy

- The National Institute for Health and Care Excellence (NICE) Clinical Guideline No. 45 ‘Antenatal and Postnatal Mental Health’ sets out screening questions that all postnatal women should be asked.

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<tr>
<th>At booking, and in the postnatal period (at least twice):</th>
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<tr>
<td>During the past month, have you often felt down, depressed or hopeless?</td>
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<td>During the past month, have you often been bothered by having little interest or pleasure in doing things?</td>
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<td>Are these feelings something you need or want help with?</td>
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Postpartum Sleep Deprivation

Rahaf Hasanein
• One of the most common post-birth side effects as well as one of the most damaging.

• Newborn has no set circadian rhythms.
• Firstly, a good few hours of sleep are essential for your body to cope with all the stress it has been exposed to. REM (Rapid Eye Movement) sleep is when our brains process the days events as well as sorting through memories. If we don’t have adequate REM sleep, it can lead to memory lapses as well as making tasks that require cognitive abilities much more challenging.

• Secondly, more serious side effects of sleep deprivation include severe depression.

• Thirdly, A mother is also often a baby’s only source of nutrition which makes her sleeping schedule a top priority. A lack of sleep can affect the quantity of milk that is being produced.
Dealing with postpartum sleep deprivation

• Communicate
  With her partner and family.
• Sleep When Your Baby Sleeps.
• Ask For Help.
• Limit Caffeine.
• natural remedies.
• Meditations.
Postpartum (non-psychotic) depressive illness
Most of postpartum women report symptoms consistent with “baby blues,” which may last several days. If the symptoms persist longer than 2 weeks, evaluation is indicated for postpartum depression.

It usually starts within the first month after childbirth (although it can occur any time within the first year) and can last weeks to months.
• Between 10% and 15% of women will suffer with some form of depression in the first year after the delivery of their baby.

• At least 7% will satisfy the criteria for mild major depressive illness, and many more could be described as having minor depression.

• 3–5% will suffer a severe major postnatal depressive episode.

• Without treatment, most women will recover spontaneously within 3–6 months; however, 1 in 10 will remain depressed at 1 year.

• The recurrence rate of postnatal depression is as high as 50%.
Symptoms of severe postnatal depressive disorder

- Early-morning wakening.
- Poor appetite.
- Diurnal mood variation (worse in the mornings).
- Low energy and libido.
- Loss of enjoyment.
- Lack of interest.

- Impaired concentration
- Tearfulness.
- Feelings of guilt and failure.
- Anxiety.
- Thoughts of self-harm/suicide.
- Thoughts of harm to the baby.
Screening and Diagnosis

• **Screening:**
  1. NICE.
  2. Edinburgh Postnatal Depression Scale (EPDS).

• **Diagnosis:**
  DSM-5 criteria for major depressive illness.
• Severe postnatal affective disorders usually present earlier than milder forms, and in this group, **biological risk factors** may be more important than psychosocial factors.
Adverse sequelae of postnatal depressive illness

Immediate
• Physical morbidity.
• Suicide/infanticide.
• Prolonged psychiatric morbidity.
• Damaged social attachment to infant.
• Disrupted emotional development of infant.

Later
Social/cognitive effects on the child.
Psychiatric morbidity in the child.
Marital breakdown.
Future mental health problems
Risk factors for postnatal depressive illness

• Past history of psychiatric illness.
• Depression during pregnancy.
• Obstetric factors (e.g. caesarean section/fetal or neonatal loss).
• Social isolation and deprivation.
• Poor relationships.
• Recent adverse life events (bereavement/illness).
• Severe postnatal ‘blues’.
Treatment options include:

1. Remedy of social factors.
2. Non-directive counselling.
3. Interpersonal psychotherapy.
5. Drug therapy.

Tricyclic antidepressants or selective serotonin reuptake inhibitors (SSRIs) are appropriate. There is good evidence to support the safety of the former in breastfeeding, less so for the latter. However, SSRIs in usual doses are probably safe.

Women with a past history of severe postnatal depressive illness may be candidates for some form of prophylactic treatment, and the help of a specialist in perinatal mental health care should be sought before delivery.
Puerperal psychosis

Selena Abboud
• puerperal psychosis or postnatal psychosis.

• Severe acute mental disorder or a psychotic reaction that develops in the early post natal period.

• Affects between 1:500 and 1:1,000 women.

• It rarely presents before the 3rd postpartum day (most commonly the 5th), but usually does so before 4 weeks.

• The onset is abrupt, with a rapidly changing clinical picture.
Causes

• **Hormone** level changes: oestrogen, progesterone

• **Disturbed sleep** patterns

• **Genetics**: chromosome 16

• **Family history**

• **Personal history** of depressive episodes specially (Prenatal anxiety or Prenatal depression)
• Lack of social and emotional support

• Low self-esteem due to a woman’s postpartum appearance

• Financial problems /Low socioeconomic status

• Poor marital relationship /Single parent

• Childcare stress

• Unplanned/unwanted pregnancy
Other organic causes

- Ischaemic or haemorrhagic stroke
- Electrolyte imbalance such as hyponatraemia or hypernatraemia
- Hypoglycaemia or hyperglycaemia
- Thyroid or parathyroid abnormalities (hyperthyroidism, hypothyroidism, hypercalcaemia, hypocalcaemia)
- Vitamin B12, folate or thiamine deficiencies
- Side-effects of medication
- Sepsis
- Substance abuse
Unbeknown to us, the “perfect storm” of risk factors had gathered...

- Sleep deprivation
- Previous episodes of depression
- Infection & fever
- Traumatic labour
- (Unknown) family history
- Within 24 hours... Psychosis
- Worries over breastfeeding
Risk factors

• Previous history of puerperal psychosis.

• Previous history of severe non-postpartum depressive illness.

• Family history (first/second-degree relative) of bipolar disorder/affective psychosis.
Symptoms

• Restless agitation/high mood (mania)/ crying spells.

• Insomnia. ( first sign of mania )

• Perplexity/confusion.

• Fear/suspicion.

• Delusions/hallucinations ( auditory )
• Failure to eat and drink.

• Thoughts of self-harm.

• Depressive symptoms (low mood, guilt, self-worthlessness, hopelessness).

• Loss of insight.

• Memory impairment.

• Illogical thoughts.
• **Feeling of Resentment**, e.g., where the mothering role turns into a resentment of the infant, questioning her decision to have had the child.

• **Feeling of inadequacy**, e.g., the feeling of being unable to cope with the baby and the daily requirements, also carrying out other activities, such as self-care and managing the household.

• **Misrecognition**—not recognising her partner or the father of the child, or mistaking others (such as male staff) for her partner or the father of the child.

• **Depersonalisation**—the mother may find it difficult to relate to the environment around her and may feel detached from reality. There is a loss of contact with her own personal reality, and this may result in her having difficulty in relating emotionally to her child.
Complications

1. Suicide

2. Infanticide

3. Homicidal thoughts

4. Lack of a normal mother-infant bond: difficulty in caring for the baby

5. Marital/Family problems
Management

• Should be treated as a **medical emergency**

1- Urgent referral to a **psychiatrist** and usually the patient requires ***admission*** to a psychiatric unit.

• If possible, this should be a mother-and-baby unit under the supervision of a specialist perinatal mental healthcare team. to prevent separation of the baby from its mother and this may help with bonding and the future relationship
2- Medication/Pharmacotherapy

- **Antipsychotics**: neuroleptics such as chlorpromazine or haloperidol.

- **Mood stabilisers** for mania: lithium carbonate.

- **Antidepressants** (take 10–14 days to be effective) second-line treatment.

- **Antianxiety drugs**
Breastfeeding is contraindicated in the case of puerperal psychosis.

During lithium treatment: should avoid breast-feeding due to potential toxicity in the infant.

Most antipsychotics are excreted in the breast milk, although there is little evidence of it causing problems.

Where they are prescribed to breast-feeding women, the baby should be monitored for side-effects.

Clozapine is associated with agranulocytosis and should not be given to breast-feeding women.
3- Psychotherapy, Cognitive behavioural therapy.

4- Electroconvulsive therapy, particularly for severe depressive psychoses.

5- Education for mother and family (Husband) and/or Social support

6- Rest

7- Adequate nutrition
• **Recovery** occurs **over 4–6 weeks**, although treatment with antidepressants will be needed for at least 6 months.

• **High** risk of pregnancy-related and non-pregnancy-related recurrences.

• The risk of recurrence in a future pregnancy is approximately **1 in 2**, particularly if the **next pregnancy occurs within 2 years** of the one complicated by puerperal psychosis.

• Women with a **previous history** of puerperal psychosis should be considered for **prophylactic lithium**, started on the **first postpartum day**.
Thank You
Postpartum Anxiety Disorder

Done By: Rand Al-Shayeb
Postpartum Anxiety

Definition

Postpartum anxiety is the loss of the normal sense of balance and calm, it is a problem when it overshoots reality and affects everyday situations. [4]

Postpartum anxiety (PPA) affects about 10 percent of new moms, according to the American pregnancy association. [2]

Postpartum anxiety (PPA) impacts about 15 percent of women —nearly as many as postpartum depression (PPD). [3]

In most cases it is associated with postpartum depression.
Postpartum Anxiety
Signs and Symptoms

Keep in mind that most (if not all) new parents experience some worry. The anticipation of labor and the arrival of a new baby may all exacerbate an existing anxiety disorder. [5]

The symptoms of postpartum anxiety disorder include: [3]

• Restlessness or feeling on edge
• Thinking constantly about the safety of the baby
• Fearing that she’ll do something to harm the baby
• Growing irritable or edgy with others
• Snapping at one’s children and experiencing guilt afterwards
Postpartum Anxiety
Signs and Symptoms

You can also have physical symptoms related to postpartum anxiety, like: [1]

- Fatigue
- Heart palpitations
- Hyperventilation
- Sweating
- Nausea or vomiting
- Shakiness or trembling
- Insomnia
- Distractibility and inability to concentrate
- Appetite and sleep disturbance
- A sense of memory loss
Postpartum Anxiety

It includes:

1. Postpartum obsessive-compulsive disorder
   (worrying, and often troublesome, thoughts she can’t shut off) [3]

2. Postpartum post-traumatic stress disorder
   (anxiety tied to a difficult labor) [3]

3. Panic attacks. [1]
Postpartum Anxiety
Signs and Symptoms (OCD / Panic Disorder)

**Postpartum OCD:** obsessive, recurring thoughts about harm or even death befalling your baby. [1]

**Postpartum panic disorder:** you can have sudden panic attacks related to similar thoughts, symptoms include: [1]

- Shortness of breath or a sensation that you are choking or unable to breathe
- Intense fear of death (for you or your baby)
- Chest pain
- Dizziness
- Racing heart
Postpartum Anxiety Causes (PPTSD)

**Traumas that might cause postpartum post-traumatic stress disorder include:** [2]

- Unplanned Cesarean
- Emergency complication such as prolapsed cord
- A birth that includes invasive interventions such as the use of vacuum extractor or forceps
- Baby having to stay in NICU
- Lack of support and assurance during the delivery
- Lack of communication from the birth and support team
- Feelings of powerlessness
Postpartum Anxiety
Signs and Symptoms PPTSD

Symptoms of PPTSD may include:[2]

• Nightmares and flashbacks to the birth or trauma
• Anxiety and panic attacks
• Feeling a detachment from reality and life
• Irritability, sleeplessness, hypervigilance, startle more easily
• Avoidance of anything that brings reminders of the event such as people, places, smells, noises, feelings
• May begin re-experiencing past traumatic events, including the event that triggered the disorder
Postpartum Anxiety Risk Factors [4]

• A personal or family history of anxiety
• Previous experience with depression
• Certain symptoms of PMS (such as feeling weepy or agitated)
• Eating disorders
• Obsessive-compulsive disorder (OCD)
• Low socioeconomic status
• Unplanned or unwanted pregnancy
• Women who have had a miscarriage or stillbirth

Note: Neonatal withdrawal effects are evident in the babies born to women who have used regular higher doses of benzodiazepines during pregnancy, and their use should be limited where possible. Breastfeeding may help to reduce the severity of the neonatal withdrawal (neonatal abstinence syndrome), as small amounts do reach breast milk. [5]
Postpartum Anxiety Vs. postpartum depression

Studies shows that you can certainly have PPD and postpartum anxiety at the same time — but you may also have one without the other.

How to tell them apart: [1]

• The two can have similar physical symptoms. But with Postpartum depression, you typically feel overwhelming sadness and may have thoughts about harming yourself or your baby.

• If you have some or all of the symptoms above — but without intense depression — you may have postpartum anxiety disorder.
Postpartum Anxiety
How Long Does It Last?

• Unlike the baby blues, which last about two weeks, postpartum anxiety doesn't always go away on its own. It's crucial to seek help if anxiety is disrupting your sleep or you're constantly preoccupied with worries. [1]

• In moderate to severe untreated cases, postpartum anxiety can last indefinitely. [1]

• If you’re dealing with longer-term, severe worry and symptoms that are getting in the way of life with baby, tell your doctor — and don’t be afraid to keep bringing it up if it doesn’t get better with initial treatment. [1]
Postpartum Anxiety Treatment

• Be sure to go to your postpartum check-up with your doctor. This is usually scheduled within the first 6 weeks after delivery. Know that you can — and should — also schedule a follow-up appointment whenever you have worrisome symptoms. [1]

• Both postpartum anxiety and PPD can affect mother bond with her baby. But there are treatments available. [1]
Postpartum Anxiety 
Treatment 

A- Non-Pharmacological

1) Certain activities can help to feel more in control, Like: [1]
   1. Exercise: Six weeks of resistance training or aerobic exercise led to a remission rate of 60 percent and 40 percent, respectively.
   2. Mindfulness
   3. Relaxation techniques
   4. Psychological support (Sometimes just having someone to talk to or give her a break from baby duties makes a big difference). [4]

2) Psychotherapy (Cognitive-behavioral therapy (CBT) and Interpersonal Psychotherapy (IPT)) [3]

Changing the thinking and behavior patterns that lead to anxiety, may limit the need for drug treatment [4]
Postpartum Anxiety
Treatment

B- Pharmacological [4]
The use of medications needs to be determined on a case-by-case basis:

1. Anxiolytic
2. Antidepressant
3. Antipsychotic
References


[5] OBSTETRICS | 20th EDITION by Ten Teachers
Eating Disorder During Pregnancy

Done By: Rand Al-Shayeb
Eating Disorder
Definition

An eating disorder is a mental disorder defined by abnormal eating habits that negatively affect a person's physical or mental health [1]. This can take over your life and make you ill. Friends and family may be concerned about your wellbeing. The most common types of eating disorders are: [2]

- Anorexia
- Bulimia
- Binge eating disorder (BED)
- Other specified feeding or eating disorder (OFSED). This is diagnosed when your symptoms don’t exactly match the other types of eating disorder.

OSFED is the most common, then binge eating disorder and bulimia. Anorexia is the least common
Eating Disorders During Pregnancy

Causes

• Typically, women who have eating disorders during pregnancy, such as anorexia or bulimia, struggled with this condition prior to conceiving. For some women, the changes and symptoms associated with pregnancy may exacerbate the eating disorder, often complicating the pregnancy and jeopardizing the health of mother and baby. [3]

• For other women, pregnancy may encourage improvement or remission in their eating disorder, as the mother seeks to improve the outcome for herself and baby. [3]

• Regardless, because of the crucial needs for both mother and the developing baby, professional treatment should be sought to ensure an eating disorder is not interfering with normal growth and progression of pregnancy. [3]
Eating Disorders during Pregnancy
Signs and Symptoms[^3]

- Little to no weight gain or weight loss throughout the pregnancy
- Restriction of major food groups
- Feeling fearful of becoming overweight
- Engaging in extreme forms of exercise to burn calories
- Inducing vomiting to get rid of food eaten
- Chronic fatigue
- Dizziness, headaches, blacking-out
- Skipping or avoiding meals
- Difficulty concentrating
- Social avoidance of family or friends
- Increased depression or anxiety
Eating Disorders during Pregnancy
Physical Effects [3]

These are some physical effects that may be experienced:
• Premature labor
• Low birth weight in baby
• Cardiac irregularities
• Stillbirth or fetal death
• Gestational diabetes
• Miscarriage
• Preeclampsia
• Complications during labor
• Respiratory Difficulties
• Abnormal fetal growth
• Increased risk of cesarean birth
• Difficulties in breastfeeding
Eating Disorders during Pregnancy

Psychological Effects

Psychological Effects – Eating disorders will have a tremendous impact on mental health, particularly if it is left untreated. Some of the psychological effects that may be experienced include:

• Postpartum depression
• Anxiety or panic attacks
• Low self-esteem
• Poor body image
• Suicidal ideations
Eating Disorders during Pregnancy
Social Effects [3]

Effects of eating disorders during pregnancy on one’s social life include:
• Withdrawal or isolation from loved ones, social functions or events
• Lack of enjoyment in hobbies or activities once enjoyed
• Marital or familial conflicts
Eating Disorder During Pregnancy Treatment

Effective eating disorder treatment during pregnancy will include:

• Regular visits with Obstetric Doctor to closely track the growth and development of baby. [3]

• A counselor or therapist who can help guide her through any fears or concerns she may be facing, and a nutritionist, who help ensure she is in-taking adequate nutrition for her and her baby. [3]

• Finding a support group and attending pregnancy or parenting classes can also be helpful in her journey as she prepare to become a mother. [3]

• Psychotherapy (Cognitive-behavioral therapy (CBT)) [4]
Postpartum Eating Disorders

• Just as pregnancy can impact the course of an eating disorder in a variety of ways, so too can the postpartum period. For women whose symptoms improve during pregnancy, two different post-partum patterns have been observed: some will continue to show decreased eating disorder symptoms following giving birth, while others relapse [5].

High Risk

• The period after a woman has given birth is a high-risk time for the recurrence or exacerbation of eating disorder symptoms, especially in those whose symptoms decreased during pregnancy.

• Women experience tremendous pressure to return to their pre-pregnancy bodies and weight. This pressure can be especially distressing to those with an eating disorder. [5]
Postpartum Eating Disorders

Depression

• Women with current or past eating disorders also appear to have higher rates of postpartum depression, which can also be a serious problem. [5]

Relapse

• Relapse rates among women with eating disorders who give birth are significant, indicating that women should remain in treatment through the postpartum period, even if their symptoms improved during the pregnancy. [5]
References


Thank You