THE Puerperium/Puerperal Psychological Aspects

Presented by: Group D4
WHAT WE ARE GOING TO TALK ABOUT:

I. Psychological changes during pregnancy and peurperium.
II. Postpartum Depressive illness.
III. Puerperal psychosis.
IV. Sleep Deprivation.
V. Postpartum Anxiety Disorders.
VI. Eating disorders
Reference: OBSTETRICS | 20th EDITION by Ten Teachers
PSYCHOLOGICAL CHANGES DURING PREGNANCY AND PEURPERIUM.

Lina Hiary
"Pregnancy is a huge transition in a woman's life, and it involves a complex mix of emotions, both good and bad,"

Women should be aware of their thoughts and feelings, and to find a place to talk about these feelings and work through them.

Pregnancy emotions are a normal part of development.
The psychological state of the pregnant woman is dynamic and changes/fluctuates during every trimester.

- **Hormones**
  During pregnancy, women experience an *increase in the production of hormones, such as progesterone and estrogen*, depending on how far along they are in their pregnancy. This increase in hormones can have an impact on your emotions and your brain’s ability to monitor those emotions. This is very common and should not be a cause of concern unless you find yourself in a state of intense emotional instability and distress.

- **Stress**

- **Body changes and body image**

- **Fatigue**
1) Psychological changes during first trimester of pregnancy:

- fluctuations between positive feelings and negative ones

- variety of factors, such as pregnancy ailments (nausea/vomiting, reflux diseases, insomnia), planned/unplanned pregnancy, financial situations, family support, and a sense of loss of independence
2) Psychological changes during second trimester of pregnancy:

- The negative feelings could sometimes lessen.

- Physical changes in her body can make her uncomfortable.

- Research has suggested that the mental health problems (such as anxiety and depression) occur less commonly in the second trimester (in comparison to the first and third trimesters).
3. Psychological changes during third trimester of pregnancy:

- increasing discomfort (such as due to pelvic girdle pain/ a backache), insomnia, tiredness/ exhaustion.
- anxious feelings of baby’s arrival starts kicking in
WAYS TO COPE WITH PREGNANCY EMOTIONS

1) Self-care
2) Sleep
3) Diet
4) Support
The puerperium refers to the 6-week period following completion of the third stage of labour, when considerable adjustments occur before return to the pre-pregnant state.

During this period of physiological change, the mother is also vulnerable to psychological disturbances, which may be aggravated by adverse social circumstances.

Adequate understanding and support from her partner and family are crucial.

Difficulty in coping with the newborn infant occurs more frequently with the first baby, and vigilant surveillance is therefore necessary by the community midwife, general practitioner (GP) and health visitor.
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.

Further more, women with previous serious mental health problems are at high risk of a recurrence during both the antepartum and postpartum periods.
During the postpartum period, about 85% of women experience some type of mood disturbance. For most the symptoms are mild and short-lived; however, 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 and
3. postpartum psychosis.

It may be useful to conceptualize these disorders as existing along a continuum, where postpartum blues is the mildest and postpartum psychosis the most severe form of postpartum psychiatric illness.
Emotional and behavioral changes affect 50–80% of new mothers between days 3 and 5 of the postnatal period.

10% of all recently-delivered women develop a depressive illness.

The incidence of puerperal psychosis is 2 / 1000 births.

Women with puerperal psychosis face a 50% risk of serious mental illness at other times in their lives.
NORMAL EMOTIONAL CHANGES IN THE PUERPERIUM

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.
The following psychological disruptions should not be considered normal and require further assessment:

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’
THE PATHOPHYSIOLOGY OF POSTPARTUM AFFECTIVE DISORDERS

- neuroendocrine basis

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.
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.

If the answers to these questions raise concerns, then the woman should be referred back to her GP, to her own psychiatrist, if she has one, or to a specialist perinatal mental health team depending on the severity of the symptoms or previous history.
At booking, and in the postnatal period (at least twice):

1) During the past month, have you often felt down, depressed or hopeless?

2) During the past month, have you often been bothered by having little interest or pleasure in doing things?

3) Are these feelings something you need or want help with?
POSTPARTUM (NON-PSYCHOTIC) DEPRESSIVE ILLNESS

NOUR GHNAIMAT
Postpartum (non-psychotic) depressive illness (PPD) is a non-psychotic depression that women may experience shortly after childbirth.

Postpartum depression is different from the “baby blues,” which begin within the first three or four days of giving birth, require no treatment and lift within a few hours or days. PPD is a deeper depression that lasts much longer. 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. In more serious cases, it can develop into chronic episodes of depression.
INTRODUCTION

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.

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.

Women with a history of severe depression are at even higher risk.

Those with a history of depression not related to pregnancy carry between a 1:3 and 1:5 risk of a major postpartum depressive illness, while 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.
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.
Postpartum psychosis (also sometimes referred to as puerperal psychosis) is an acute mental disorder or a psychotic reaction occurring in a woman following childbirth, or abortion. The episode of psychosis usually begins 1 to 3 months of delivery. It rarely presents before the 3rd postpartum day (most commonly the 5th), but usually does so before 4 weeks. The onset is characteristically abrupt, with a rapidly changing clinical picture.
EPIDEMIOLOGY

**incidence:**

This very severe disorder affects between 1:500 and 1:1,000 women after delivery.

JORDAN

Another cross-sectional correlational study was done in 2015 examined post-partum depression and its relationship with demographic, maternal, and infant health problems in urban Jordanian women. Participants (n = 315) were selected from five maternal child healthcare centers and one major hospital in Amman, Jordan. Patient Health Questionnaire-9 was used to measure post-partum depression within 12 weeks of birth. A number of socio-demographic and health problems were examined for an association with post-partum depression. Results showed that 25% of post-partum women suffered moderate to severe depression with psychosis and 50% of the sample had mild depression.

N=852

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Table (17): Pattern of PP morbidity as reported by mothers in AL-Balqa Governorate, Jordan, 2006.
AETIOLOGY

The precise cause is unknown. However, the following serve as risk factors to the development of postnatal psychosis:

- Genetic/Hereditary, e.g., chromosome 16
- Hormonal changes, e.g., oestrogen, progesterone, etc.
- Family/Personal history of depressive episodes specially (Prenatal anxiety or Prenatal depression)
- Lack of social and emotional support
- Low sense of self-esteem due to a woman’s postpartum appearance
- Financial problems /Low socioeconomic status
- Poor marital relationship /Single parent
- Childcare stress
- Unplanned/unwanted pregnancy
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
RISK FACTORS FOR POSTPARTUM PSYCHOSIS

1. Previous history of puerperal psychosis.
2. Previous history of severe non-postpartum depressive illness.
3. Family history (first/second-degree relative) of bipolar disorder/affective psychosis.
SYMPTOMS OF PUERPERAL PSYCHOSIS

1. Restless agitation. (Crying spells)
2. Insomnia.
3. confusion.
4. Fear/suspicion.
5. Delusions e.g., baby is a Messiah, or an embodiment of evil
6. Hallucinations, e.g., auditory – commanding the patient to kill baby
7. Failure to eat and drink.
8. Thoughts of self-harm.
10. Loss of insight
11. Feeling of Resentment, e.g., where the mothering role turns into a resentment of the infant, questioning her decision to have had the child.
12. **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.

13. **Misrecognition** – can be common and may take the form of 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.

14. **Mood disturbances** – can be both manic and depressive in nature. Often mothers may present as having difficulty in sleeping, which can be the first sign of a euphoric or manic state.

15. **Depersonalisation** – during the depersonalisation phase 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. This, of course, has repercussions in terms of the mother’s ability to bond with her baby.
COMPLICATION:

1. Suicide
2. Infanticide
3. Homicidal thoughts
4. Lack of a normal mother-infant bond, i.e., difficulty in caring for the baby
5. Marital/Family problems
MANAGEMENT

1. **Rapid/Immediate hospitalization** – if she is thought to pose a threat to baby, herself or others
   ✓ - referred urgently to a psychiatric unit.
   ✓ - mother-and-baby unit under the supervision of a specialist perinatal mental healthcare team. Prevent separation / bonding and the future relationship.

2. **Medication/Pharmacotherapy** –
   a. Antipsychotic drugs (acutely use neuroleptics, such as chlorpromazine or haloperidol.)
   b. Antidepressants (which will take 10–14 days to be effective) as a second-line treatment
   c. Antianxiety drugs
   d. Acute pharmacotherapy with Treatment of mania with lithium carbonate

   > Recovery usually occurs over 4–6 weeks, although treatment with antidepressants will be needed for at least 6 months.

   > NB: Breastfeeding is contraindicated in the case of puerperal psychosis. Lithium treatment no breast-feed, 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. Electroconvulsive therapy, particularly for severe depressive psychoses.

4. Psychological counselling, i.e., psychotherapy /Support group therapy, e.g., Establishing contact with other mothers

5. Education for mother and family -Family, Husband and/or Social support

6. Rest

7. Adequate nutrition
PROGNOSIS AND RECURRENCE

• These women remain at 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.
Sleep deprivation is one of the most common post-birth side effects as well as one of the most damaging. While you may think it’s alright to neglect your sleep, even a small period of sleep loss can have long lasting effects.
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

One of the biggest reasons a mother struggles to get adequate sleep is she doesn’t communicate her needs to her partner and family.

Sleep When Your Baby Sleeps

Ask For Help
WHAT IS POSTPARTUM ANXIETY?

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.

That affects about 10 percent of new moms, according to the American Pregnancy Association.

In most cases it is associated with Postpartum depression.
It is include:

1. *postpartum obsessive-compulsive disorder*
   (worrying, and often troublesome, thoughts she can’t shut off)

2. *postpartum post-traumatic stress disorder*
   (anxiety tied to a difficult labor)

3. panic attacks.
HOW TO SPOT THE SIGNS AND SYMPTOMS?

The symptoms of postpartum anxiety, in addition to the hard-to-shake intrusive thoughts, include:

- **restlessness** or feeling on edge
- **thinking constantly** about the safety of the baby
- **fearing** that you’ll do something to harm the baby
- **growing irritable or edgy with others**
- **snapping** at one’s children and experiencing **guilt** afterwards
As if all that wasn’t enough, you can also have physical symptoms related to postpartum anxiety, like:

- 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
there are some factors that might increase your risk. These include:

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
HOW LONG DOES POSTPARTUM ANXIETY 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.

In moderate to severe untreated cases, postpartum anxiety can last indefinitely.
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.

Both postpartum anxiety and PPD can affect mother bond with her baby. But there is treatment available.
NONPHARMACOLOGICAL:

* Certain activities can help to feel more in control, like:

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**

5. Sometimes just having someone to talk to or give her a break from baby duties makes a big difference."

* **Cognitive-behavioral therapy (CBT)** by changing the thinking and behavior patterns that lead to anxiety.
PHARMACOLOGICAL:

a. Anxyolitics
b. Antidepressant
c. Antipsychotic
EATING DISORDER DURING PREGNANCY

Presented by: Rahmeh Alsukkar
An eating disorder is when you have an unhealthy relationship with food, weight or body image. 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:

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.
CAUSES OF EATING DISORDERS DURING PREGNANCY

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.

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. 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.
SIGNS AND SYMPTOMS OF EATING DISORDERS DURING PREGNANCY

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
EFFECTS OF EATING DISORDERS DURING PREGNANCY

Physical Effects — 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 breastfeeding
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
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 TREATMENT DURING PREGNANCY

Effective eating disorder treatment during pregnancy will include regular visits with Obstetric Doctor to closely track the growth and development of baby, 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.

Finding a support group and attending pregnancy or parenting classes can also be helpful in her journey as she prepare to become a mother.
DONE BY D4:

THANK YOU