OBSTETRICS

Perinatal psychiatric disorders: an overview

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Perinatal mental illness has a significant implication on maternal health, birth outcomes, and the offspring's development. Prevalence estimates of perinatal psychiatric illnesses range widely, with substantial heterogeneity in different population studies, with a lower prevalence rate in high- rather than low- or middle-income countries. Because of the potential negative impact on maternal and child outcomes and the potential lability of these disorders, the perinatal period is a critical time to identify psychiatric illnesses. Thus, obstetricians and midwives play a crucial role in assessing women's mental health needs and to refer identified women promptly for multidisciplinary specialist assessment. However, there is still limited evidence on best practice assessment and management policies during pregnancy and postpartum. This review focuses on the prevalence of common perinatal mental disorders and antenatal screening policies to identify women at risk. The effect of these conditions and their management on pregnancy, fetal outcomes, and child development are discussed.

Key words: childbirth, mental illness, offspring, postpartum, pregnancy

Over the past decade, Perinatal Mental Health (PNMH) has gained increased attention in policy documents, medical literature, and the media. This was particularly triggered by reports from the United Kingdom, demonstrating that PNMH was the leading cause of maternal mortality within the first year postpartum.[1] Thus, health services in several countries are focused on implementing clinical management systems that ensure the delivery of high-quality services for this group of vulnerable women.[2,3] These policies have reduced PNMH-related maternal mortality.[4] However, the impact of these services on other maternal, fetal, and child outcomes is less clear. The recommendation for effective multidisciplinary PNMH services has not been complemented by clear guidance about service structure, and currently service delivery is highly variable.[5]

The purpose of this review is to summarize the current literature on perinatal psychiatric illness, focusing on the magnitude of the problem, and review current screening policies, examining risk factors and critically evaluating the impact of suggested evidence based managements on maternal, fetal, and child outcomes.

Classification

Perinatal psychiatric disorders (Figure 1) are wide ranging and can arise for the first time during the perinatal period or may represent a relapse of a preexisting condition. In Western societies, estimates of mental health problems during the perinatal period range considerably, with substantial heterogeneity in different population studies.[6-8] Mood and anxiety disorders are the most prevalent mental illnesses found during this period.[7-12] Literature reports higher rates of perinatal psychiatric disorders in low- and lower-middle-income countries.[13-15] Less than 8% of women suspected to have perinatal mental illnesses are currently receiving any type of mental health care in these countries.[16] There is a well-documented variation in prevalence by ethnic origin.[17,18]

Mood disorders

Mood disorders include perinatal depression and bipolar affective disorder (BPAD). Perinatal depression can occur either during pregnancy or within the first 12 months after delivery. This diagnosis is made if the woman suffers with consistently low mood along with a fixed number of biological or cognitive symptoms for at least 2 consecutive weeks. Epidemiological studies in Western societies reported rates of antenatal and postnatal depressive episodes ranging between 5%,[12,19] 33%,[6,8,9,11,20-26] and 10-15%,[6,19,23,27-29] respectively.

Higher prevalence rates seem to occur in low-income settings.[30-34] It is imperative to differentiate postnatal depression from postnatal blues. The latter is regarded as a normal variation of emotional change occurring after childbirth[35] in which as high as 50-85% of women can experience symptoms of mild depressive symptoms, anxiety, irritability, mood swings, and increased tearfulness. Postnatal blues typically peak on the fourth or fifth day postpartum and usually resolve spontaneously by day 10.[36,37]

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Received May 31, 2013; revised Oct. 2, 2013; accepted Oct. 4, 2013.

There was no specific funding for this review. E.P. is a Clinical Research Fellow at Birmingham Women's National Health Service Foundation Trust funded by the Department of Neuroscience, Postgraduate School of Psychiatry, Psychiatric Clinic, University of Turin (Italy).

The authors report no conflict of interest.

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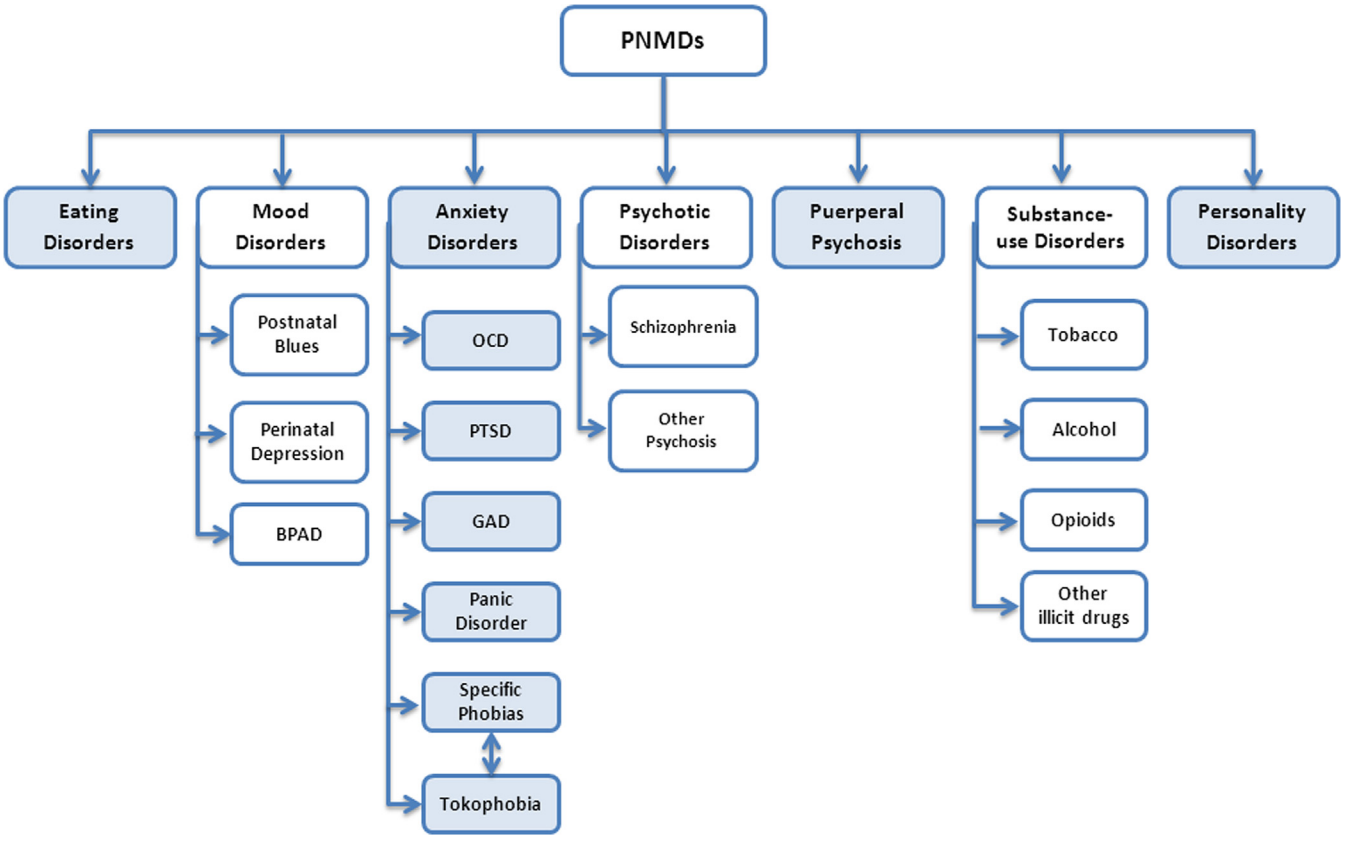
0002-9378/$36.00

http://dx.doi.org/10.1016/j.ajog.2013.10.009

FIGURE 1
Classification of common perinatal mental disorders



This figure summarizes common perinatal psychiatric disorders that can occur during the perinatal period.

GAD, generalized anxiety disorder; *OCD*, obsessive-compulsive disorder; *PNMD*, perinatal mental disorders; *PTSD*, posttraumatic stress disorder.

Paschetta. Perinatal Mental Health. Am J Obstet Gynecol 2013.

BPAD is characterized by episodes of mania or hypomania, typically alternating with episodes of depression. Childbirth is often related to the initial onset of BPAD.[38,39] Up to 50% of women with a history of BPAD have a risk of relapse perinatally,[40,41] especially after childbirth, when this risk is higher for BPAD than any other form of mental illness.[42] Studies indicate that the risk of relapse is highest in the first 2 weeks postpartum, typically commencing as early as between days 2 and 4.[43]

Anxiety disorders

A wide range of anxiety disorders are seen perinatally; these include obsessive compulsive disorder (OCD), posttraumatic stress disorder (PTSD), generalized anxiety disorder (GAD), panic disorder, and specific phobias. Their reported prevalence rates range from 4.5%[34] to 15%.[20,22,31,44] Some authors suggest that following childbirth, an increasing proportion of women experience PTSD.[45-48] However, other studies report higher rates of OCD and GAD in postpartum women compared with general population.[49-52]

Among specific phobias, tokophobia (a morbid fear of childbirth) is gaining increased attention in clinical practice, especially for the high perinatal comorbidity with mood and anxiety disorders[53] and the frequent request of elective cesarean section. Preliminary reports have shown that treatment for tokophobia and comorbid psychiatric conditions[53] during pregnancy can lead to a significant reduction of the fear of vaginal delivery with a withdrawal in request for cesarean sections.[54-57]

Psychotic disorders

The lifetime prevalence of schizophrenia is approximately 1-2%.[58] Key manifestations of disease include psychotic symptoms such as hallucinations and delusions, affective disturbances such as emotional blunting, and significant occupational and social dysfunction. The risk of relapse during the first 3 months postpartum is approximately 24-25%,[59,60] especially following treatment discontinuation.[61,62]

Puerperal psychosis

This is reported to occur following 1-2 per 1000 births,[29,63-65] and has its onset commonly within the first 2 weeks postpartum.[42,66] Women usually develop paranoid, grandiose, or bizarre delusions, mood lability, and perplexity. These features represent a dramatic