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Perinatal mental illness: Definition, description and aetiology

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Perinatal mental illness is a significant complication of pregnancy and the postpartum period. These disorders include depression, anxiety disorders, and postpartum psychosis, which usually manifests as bipolar disorder. Perinatal depression and anxiety are common, with prevalence rates for major and minor depression up to almost 20% during pregnancy and the first 3 months postpartum. Postpartum blues are a common but lesser manifestation of postpartum affective disturbance. Perinatal psychiatric disorders impair a woman's function and are associated with suboptimal development of her offspring. Risk factors include past history of depression, anxiety, or bipolar disorder, as well psychosocial factors, such as ongoing conflict with the partner, poor social support, and ongoing stressful life events. Early symptoms of depression, anxiety, and mania can be detected through screening in pregnancy and the postpartum period. Early detection and effective management of perinatal psychiatric disorders are critical for the welfare of women and their offspring.

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Introduction

Perinatal mental illness is a significant complication of pregnancy and the postpartum period, and is frequently encountered by the obstetrician–gynaecologist. The chapters in this issue of *Best Practice and Research Clinical Obstetrics and Gynaecology* are principally concerned with the most prevalent disorders: major depression, bipolar disorder, and the anxiety disorders. In this chapter, we describe the various forms of perinatal mental illness and address issues relating to epidemiology and risk factors. Subsequent chapters will address detection of perinatal mental illness, effect of perinatal stress, anxiety, and psychotropic medications on the developing fetus and infant, the long-term prognosis of perinatal mental illness, the varieties of psychological and medical treatments, and psychiatric management of sleep disturbance and perinatal loss. The contributions come from colleagues in the USA, Canada, UK, Australia, France, India, and Pakistan, which gives this issue of *Best Practice and Research Clinical Obstetrics and Gynaecology* a diverse and international perspective on the problem and management of perinatal mental illness.

Perinatal mental illness has been recognised since the time of Hippocrates, and commented on through the centuries. In the 19th century, medical interest in perinatal mental illness accelerated, along with more general interest in severe mental illness. Marcé [1], the namesake of the major international society devoted to the study of perinatal mental illness (the Marcé Society for Perinatal Mental Health), published an important series of case studies of women suffering from various forms of perinatal mental illness over 150 years ago. Across the 20th century, clinical accounts and research on prevalence, risk factors, consequences to the mother, fetus, and infant expanded dramatically. Numerous government agencies and professional groups have issued guidelines for the detection and management of perinatal mental illness [2–5]. Increased clinical and professional attention, and financial resources directed towards perinatal mental illness are warranted given the significant effect of these psychiatric disorders on the lives of women, their children, and their families.

Studies on perinatal mental health also have been influenced by concepts emerging over the past 2 decades relating to the centrality of the fetal milieu in shaping health throughout the individual's life. The dynamic mix of biological, socio-environmental and psychological factors affect the expression of disease (and health) across the life span [6]. Fetal programming refers to the capacity of the in-utero environment to modify the expression of genes and interact with the genetic substrate to determine disease susceptibility in the short- and long-term. High levels of stress and associated mental illnesses affect maternal and fetal outcomes, and also long-term offspring health into adulthood. To the extent that negative biopsychosocial exposures can be diminished, eliminated, or replaced with positive factors, childbearing outcomes and the subsequent health of the mother of an offspring can be improved. Focusing intervention on the perinatal period builds upon women's interest in embracing positive health behaviours to invest in the welfare of their offspring, such as decreased smoking and alcohol use. This exciting area of investigation is reviewed in this issue by Vivette Glover.

Definition of perinatal mental illness

Perinatal mental illness refers to psychiatric disorders that are prevalent during pregnancy and as long as 1 year after delivery. The postpartum time-frame is debatable: most investigators use a period ranging from 4 weeks after delivery to 3 months after delivery. Perinatal disorders ranging from mild depression and anxiety, mania, to florid psychosis all fall under the rubric of perinatal mental illness. Additionally, disorders that were present before pregnancy, or recurring along with disorders that emerge during pregnancy or in the postpartum period, are all considered perinatal mental illnesses. Among disorders that emerge in the postpartum period, some emerge soon after childbirth, and others emerge later or more variably. Do aetiology or prevention and treatment make a difference to any of these distinctions? What does the practising obstetrician need to know? It is most important for the obstetrician to recognise psychiatric disorders that begin before pregnancy and carry on into pregnancy, or that emerge during pregnancy, or that are prevalent in the early postpartum period. In addition, the obstetrician should be aware of risk factors for perinatal mental illness, and treatment and referral options.