

Mental Illness in the Peripartum Period

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Women experience unprecedented hopes when they become pregnant and give birth. However, with the advent of motherhood, women must also contend with formidable challenges. Along with the powerful hormonal changes that occur in their bodies, they face major adjustments in relationships, changes in appetite and weight, sleep disturbances, the pain of childbirth, and the stresses of caring for a newborn.

Women in the childbearing years are particularly vulnerable for either developing a mental illness or experiencing symptom exacerbation, in part because of the psychological, hormonal, and physical changes as well as stress that accompany pregnancy and childbirth. Other factors, however, can contribute to vulnerability to mental illness in this period: (a) family or personal history of mental illness, (b) young age, (c) poor support, (d) history of prior miscarriage or stillbirth, or (e) an unwanted pregnancy. Women who develop a mental illness in this time period face multiple challenges. As they experience the stresses and joys associated with bearing and raising children, they must also manage and come to terms with their illness (Ackerson, 2003). Because mental illness can greatly impair parenting (Mowbray, Oyserman, Zemencuk, & Ross, 1995) and affect both the mother–infant attachment bond and a baby’s well-being (Lyons-Ruth, Wolfe, & Lyubchik, 2000), it is critical to detect, diagnose, and treat peripartum mental illness as soon as possible.

Many new mothers experiencing mental illness, however, do not tell others about their symptoms. Many also fail to seek out the help that they need, even though their symptoms may be seriously interfering with their well-being and with their ability to care for their baby. Yet, if adequate treatment is delayed, it can influence how long the illness lasts and to what extent parenting is influenced. Understanding why some women hide their symptoms is therefore critical for detecting and diagnosing mental illnesses, and engaging women in treatment.

Three conditions are typically associated with the peripartum period: the postpartum “blues,” postpartum depression, and postpartum psychosis (Brockington, 2004). Of these conditions, the blues are not a psychiatric disorder and require no treatment. However, postpartum depression and psychosis are psychiatric conditions and can create significant risks for mother and baby alike. Anxiety-, eating-, and trauma-related disorders can also present in the peripartum period, but until recently these conditions have received little systematic attention (Ross & McLean, 2006).

This article provides an overview of peripartum mental illness. It describes how different psychiatric disorders may present in pregnancy and the postpartum period, and how they can affect parenting. The reasons why women do not tell others about their symptoms are also explored, with the aim of finding ways to facilitate early detection, diagnosis, and engagement in treatment. Detailed reviews of treatments for peripartum mental illness and the effects of peripartum disorders on babies are listed in the Learn More section.

The “Baby Blues”

THE POSTPARTUM BLUES (also called maternity or baby blues) are distinct from postpartum depression (Miller, 2002). A common condition that many women experience right after birth, the blues usually start with the onset of lactation, that is, 3 to 5 days after birth. It is a transient state, usually lasting a few hours or days only. It is estimated that about 50% of women who give birth experience the blues. Women

who develop this condition are emotionally reactive. They burst easily into tears and are more irritable than usual, but their predominant mood is happiness (Kendell, McGuire, Connor, & Cox, 1981). The blues may result from abrupt hormonal withdrawal that occurs after birth. Alternately, the condition may result from the activation of the biological system that is regulated by the hormone oxytocin and that underlies mother–infant attachment (Miller, 2002). The blues are not a psychiatric condition and require no treatment, but support from others can make a difference. A mother who has the blues and who has little support and a high level of stress may be more vulnerable than other mothers to developing postpartum depression, a condition that does need treatment.

Major Depression

ONE IN 10 women becomes clinically depressed when pregnant. About 10% to 20% experience an episode of clinical depression in the postpartum period

Abstract

Women are particularly vulnerable in the peripartum period for either developing a mental illness or suffering symptom exacerbation. These illnesses are often experienced covertly, however, and women may not seek out professional help, even though their symptoms may be seriously affecting their well-being and parenting. This article provides an overview of mental illnesses that can present in the peripartum period, with the aim of improving their early detection, diagnosis, and treatment by health professionals. The author examines the risks that peripartum mental illness may pose to parenting and explore reasons why many women keep their illness secret.

(Chaudron, 2003). Women who develop postpartum depression experience the same symptoms as individuals who develop depression at other times in their lives, but the timing of the illness is unique. Symptoms generally emerge within the first 6 months after childbirth (Epperson & Ballew, 2006). A woman who develops clinical or major depression experiences a sustained period of depressed or despondent mood. Her sleep and appetite may become disturbed. She may feel restless, have difficulties concentrating, and lose interest in activities that she had previously enjoyed. In addition, she may feel guilty or worthless, or may think about suicide (American Psychiatric Association, 2000).

Depression that emerges during pregnancy or in the postpartum period can create risks for mothers and babies alike. A mother who is depressed during pregnancy may fail to eat properly and may lose weight (Epperson & Ballew, 2006). She may fail to attend prenatal care and may increase her use of substances, particularly alcohol or cigarettes (Orr & Miller, 1995). Her baby may be more irritable (McGrath, Records, & Rice, 2008) and more difficult to soothe than a baby of a mother without depression.

If a mother's depression persists after childbirth, she may feel unable to cope with even the simple tasks of parenting—holding, caring for, and enjoying time with her baby. She may feel inadequate as a parent, may see her baby as bothersome, and may wish she had never gotten pregnant (Sneddon, Kerry, & Bant, 1981). Women with depression in this period often feel highly anxious in the parenting role.

Suicide is a serious risk that is associated with untreated depression (Miller & Shah, 1999). Women are at higher risk for suicide in the postpartum period if their partner has abandoned them, if they have lost a prior child, or if they wanted to obtain an abortion but were unable to (Lester & Beck, 1988; Wisner, Peindl, & Hanusa, 1994).

Depression in the peripartum period often goes unrecognized—by the mothers, by their families, and even by health professionals (Beck, 2001). One reason for the lack of detection of depression during pregnancy is the overlapping nature of symptoms. It can be hard to tell whether a mother's lack of energy, sleep problems, and weight gain are signs of depression or normal symptoms that accompany pregnancy (Miller & Shah, 1999).

Another reason why depressive symptoms go unrecognized is that many women hide their symptoms from others (Beck, 2001). New mothers may conceal symptoms because of the stigma associated with mental illness, because they are ashamed to be depressed at a time when women should be happy, and because they believe that others close to

them do not want to hear about their symptoms. Some women may not talk about their symptoms because they fear others will think they are crazy or doubt their ability to parent. Women may also fear that if they talk about their symptoms, their children may be taken away.

Knowing the risk factors for peripartum depression is critical for early detection and diagnosis (Beck, 2001). See the sidebars for Predictors of Depression During Pregnancy and Predictors of Postpartum Depression. Remember: Postpartum depression is often a continuation of a depressive episode that started during pregnancy.

Anxiety Disorders

BETWEEN 9% AND 30% of women experience serious symptoms of anxiety in the peripartum period (Wenzel, Haugen, Jackson, & Robinson, 2003). Reasons why women are at increased risk for developing anxiety disorders in this period include the increase in their cortisol levels, new stresses, adjusting to new expectations, and sleep deprivation during pregnancy and postpartum (Wenzel et al., 2003).

PREDICTORS OF DEPRESSION DURING PREGNANCY

The following factors increase a women's risk for depression during pregnancy:

- History of depression
- Absent partner
- Conflicted relationship with partner
- History of loss, including loss of parent
- High stress levels

Source: Miller & Shah, 1999

PREDICTORS OF POSTPARTUM DEPRESSION

Women are more likely to suffer from postpartum depression if they have:

- A prior history of depression or prenatal depression
- Prenatal anxiety
- Low self-esteem
- A high level of child care stress
- Life stress
- Poor or inadequate social support
- Marital difficulties
- A baby with a difficult temperament
- Experienced the maternity blues

Source: Beck, 2001

Generalized Anxiety Disorder and Panic Disorder

Women who develop generalized anxiety disorder (GAD) experience uncontrollable and excessive worry over a prolonged period of time. They may worry about relationships, work, or health. They also experience many physical symptoms, such as irritability, muscle tension, and restlessness. While most individuals have some worries, especially in periods of stress, individuals who develop this disorder cannot control their concerns. Much of their time, energy, and coping abilities are spent in worrying.

During pregnancy and the postpartum period, women who develop GAD may worry excessively about their baby's well-being, about their ability to cope with the tasks and stresses of parenting, and about finances. About 8% of women meet criteria for GAD in the postpartum period (Wenzel et al., 2003).

A woman who develops panic disorder (PD), another type of anxiety disorder, experiences discrete, recurrent episodes of extreme anxiety. Panic attacks also include physiological symptoms: shortness of breath, chest pains, palpitations, hyperventilation, dizziness, and sweating (American Psychiatric Association, 2000). Symptoms associated with pregnancy such as shortness of breath, dizziness, and rapid heart rate can place women at risk for a recurrence of PD (Abramowitz, Larsen, & Moore, 2006). A woman who has a preexisting PD may interpret these symptoms in a catastrophic manner and believe she is experiencing a heart attack.

Panic attacks that occur during pregnancy can affect how a woman cares for her unborn baby. A woman who has agoraphobia along with PD may avoid leaving home and may struggle to attend prenatal visits or even to make it to the hospital when she is in labor (Olsen, Toepfen-Sprigg, & Krell, 1992). Some women experience fewer panic attacks during pregnancy (Levine, Oandasan, Primeau, & Berenson, 2003), only to experience more frequent attacks as they face the stresses of parenting.

Obsessive Compulsive Disorder

Obsessive compulsive disorder (OCD) is characterized by persistent and recurrent obsessions (thoughts and impulses) and behaviors (compulsions). An individual with OCD knows that the obsessions and compulsions are unreasonable, but he or she has little control over them. Pregnancy may trigger the onset of OCD in some women. Women who have a preexisting diagnosis of OCD may experience an intensification of their symptoms in this period (Abramowitz, Schwartz, Moore, & Luenzmann, 2003).

A pregnant woman with OCD may avoid foods because of fears of contamination,



Depression in the peripartum period often goes unrecognized.

or she may engage in time-consuming rituals that cause her to miss prenatal check-ups (Miller & Shah, 1999). In the postpartum period, women who develop OCD may develop obsessive worries about their baby's well-being, or they may worry obsessively that their baby will die of sudden infant death syndrome.

Women with OCD may develop intrusive obsessions about harming their newborn in the postpartum period, such as thoughts of sexually abusing, drowning, or stabbing the baby (Abramowitz et al., 2006). Women with OCD who have these thoughts fear that they might act on them, so they avoid their babies so as not to harm them (Abramowitz et al., 2006).

Symptoms of OCD should be distinguished from symptoms of postpartum psychosis. Although symptoms of both disorders can involve thoughts about harming a newborn, women with OCD are not at increased risk of committing harm, because they experience these symptoms as unwanted and senseless. By contrast, a person with delusional thinking accepts her delusions as true (Abramowitz et al., 2006).

Posttraumatic Stress Disorder

Posttraumatic stress disorder (PTSD) is an anxiety disorder closely linked to experiences of trauma. It includes symptoms of avoidance of any stimuli or memory associated with trauma, flashbacks of the trauma, and extreme startle responses (American Psychiatric Association, 2000).

Women who have a history of PTSD because of past sexual abuse may experience an exacerbation of PTSD symptoms during delivery (Miller & Shah, 1999). A pelvic

examination during labor, for instance, may remind a woman of a past rape. Fearing that she might lose control of what is happening, a woman may try to control every aspect of the delivery. During labor, she may be extremely tense (Gottwall & Waldenstroem, 2002), may dissociate, curl up in a fetal position, or resist an impulse to push (Miller & Shah, 1999). Evidence suggests that traumatic labor can contribute to PTSD symptoms in some women (Cook et al., 2004).

Health professionals should recognize that during labor, women with PTSD may be extremely anxious about being in a situation over which they have little control. Helping a woman to relax, to know what she can anticipate next, and to feel that she has some control over what is happening can make a difference (Simkin, 2008).

Eating Disorders

MOST EATING DISORDERS are diagnosed when a woman is in the childbearing years (Franko, 2006). Women rarely tell others about an eating disorder, however, and they often do not seek treatment (Mitchell-Gielegem, Mittelstaedt, & Bulik, 2002). Some do this because of the shame they feel about their eating symptoms. Others do not tell because they believe they are strong and can control the eating symptoms on their own.

Given the secrecy that can surround eating disorders, it is especially important for health professionals to recognize signs that are suggestive of an eating disorder. Warning signs that may indicate an eating disorder in pregnancy include a lack of weight gain, a history of an eating disorder, excessive vomiting (Franko & Spurrell, 2000), and weight-reducing behaviors (Stewart, 1992).

Anorexia Nervosa

Women with anorexia nervosa (AN) refuse to maintain normal weight. Some do not reach expected weight gains because of strict dieting or extreme measures such as overexercise (American Psychiatric Association, 2000). Women who develop this disorder have an obsessive preoccupation with their body shape and food, and experience intense fear about becoming fat. Women with the restrictive type of AN remain thin by fasting, exercising, or severely restricting their food intake. Women with the binge-purging type of AN binge eat and use vomiting, laxatives, diet pills, or other means to lose weight.

Women with AN often have irregular menses and difficulties with fertility, but they are still able to become pregnant (Miller & Shah, 1999). Pregnancy, however, is likely to pose formidable challenges for women with AN. Some women with AN may only note that they are pregnant after several months have gone

by. For those who do recognize that they are pregnant early on, it can be difficult to cope with the inevitable weight gain that accompanies pregnancy. With weight gain, a woman with AN may experience increased conflicts over her body image and sense of control, feelings that can exacerbate dieting and purging behaviors (Miller & Shah, 1999).

Women with AN can experience difficulties with breastfeeding (Franko, 2006). Their babies may have low Apgar scores, a small gestational age (Stewart, Raskin, Garfinkel, MacDonald, & Robinson, 1987), and undernutrition (Russell, Treasure, & Eisler, 1998).

Bulimia Nervosa

Bulimia nervosa (BN) involves repeated episodes of uncontrollable eating over a short period of time coupled with the use of dieting, purging, exercise, laxatives, enemas, or diuretics as compensatory mechanisms to prevent weight gain. Individuals with BN are typically within the normal weight range for their age and height. This disorder begins in late adolescence or early adulthood.

Pregnancy can exacerbate symptoms of BN, although some women show symptom improvement. This improvement may result from the woman controlling her symptoms so as to protect her unborn baby. In the postpartum period, however, this situation may change. During this time, a woman with BN may experience renewed obsessions with losing weight, or she may resume binge-purging behavior.

Women who have active symptoms of BN during pregnancy are more likely than other pregnant women to have a miscarriage, to deliver their baby by cesarean section, or to deliver a baby with a low birth weight (Franko, 2006). Babies of mothers with BN weigh less and may have problems with breastfeeding (Waugh & Bulik, 1999).

Women with BN are often very secretive about their symptoms. However, they may be more apt to reveal symptoms if they are asked about them in a nonjudgmental and open manner (Franko, 2006). Critical parts of treatment for both this disorder and AN in the peripartum period include helping women to manage the anxiety that results with weight gain, involving family members to help with the treatment, and identifying triggers to binge-purge cycles. The mothers need support in finding healthy ways to nourish themselves and their babies and to separate their psychological needs from their physical needs (Franko, 2006).

Bipolar Disorder

IN BIPOLAR DISORDER, episodes of depression alternate with episodes of mania or hypomania. Symptoms of mania include rapid speech, increased activity, impulsive

behavior, grandiosity, racing thoughts, and a decreased need for sleep (American Psychiatric Association, 2000). The mood swings that characterize bipolar disorder may last for days, weeks, and sometime months before subsiding. A chronic mental illness, bipolar disorder can contribute to major difficulties in functioning. Women with this illness can engage in relationships, raise families, and hold jobs, but their ability to function can also be seriously compromised, especially if the illness remains untreated.

Mania that emerges in pregnancy can result in serious complications, affecting the health of mother and baby alike. Mothers who are in a manic phase are at high risk for HIV infection (Coverdale, Turbott, & Robert, 1997) and for substance abuse (Strakowski & DelBello, 2000). A pregnant woman who is experiencing mania may refuse to participate in physical examinations or may find it impossible to maintain restrictions on her activity level, such as when ordered to stay on bed rest because of preterm labor (Miller & Shah, 1999). In the postpartum period, risks can also be high. Women with preexisting bipolar disorder are especially vulnerable for developing postpartum psychosis, one of the most severe postpartum illnesses.

Postpartum Psychosis

ARARE CONDITION, POSTPARTUM psychosis occurs in 1 or 2 in 1,000 women (Kendell et al., 1981). Postpartum psychosis affects not only the woman and her baby but all people around her (Attia, Downey, & Oberman, 1999). Starting from 3 to 14 days after childbirth, postpartum psychosis has an abrupt onset. Its symptoms are both dramatic and severe. Prominent delusions, hallucinations, confusion, and delirium are all symptoms that a woman may evidence if she develops postpartum psychosis. If a mother becomes acutely psychotic after giving birth, she may believe in bizarre ideas, thinking that her baby is still inside her womb or that the baby is deformed even though nothing is wrong (Sneddon et al., 1981).

Some mothers with postpartum psychosis harbor thoughts of killing the infant. Infanticide can occur in women with this disorder (Attia et al., 1999), but the short-term prognosis for parenting is usually good if the woman is hospitalized and treated (Sneddon et al., 1981). Some women with postpartum psychosis, however, can appear well temporarily only to soon become profoundly depressed or psychotic (Miller, 2002). Follow-up for mothers with this disorder is therefore essential.

Women are at especially high risk for developing postpartum psychosis if they have a family or personal history of bipolar mood

disorder and if they have had a prior episode of postpartum psychosis (Steiner & Tam, 1999). If a woman develops psychotic symptoms postpartum, she will usually need to be hospitalized as soon as possible.

Schizophrenia

SCHIZOPHRENIA IS A severe and chronic disorder characterized by episodes of psychotic symptoms such as delusions, hallucinations, disorganized speech, or catatonic behavior. Negative symptoms, such as flat affect, poor eye contact, and a lack of motivation to complete goal-directed activities, are also characteristic of this illness. Individuals with schizophrenia can also have cognitive symptoms such as memory problems, difficulty in focusing attention, and problems with abstract symptoms (American Psychiatric Association, 2000). Schizophrenia can have a debilitating effect on lives: Individuals experience deterioration in their social and occupational functioning.

Women who have been diagnosed with schizophrenia are more likely than women without mental illness to experience poverty and violence, to live alone, and to be estranged from their families (Seeman, 2006), all factors that can influence how a mother cares for herself and her baby. Studies show high rates of unwanted and unplanned pregnancies in women with schizophrenia (Miller & Finnerty, 1996). Women with schizophrenia are also less likely than women without this disorder to seek out prenatal care (Miller & Finnerty, 1996).



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One in 10 women becomes clinically depressed when pregnant.

Learn More

Publications

PARENTAL PSYCHIATRIC DISORDER: DISTRESSED PARENTS AND THEIR FAMILIES (2ND ED.)
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Web Sites

NATIONAL ALLIANCE ON MENTAL ILLNESS

www.nami.org

The National Alliance on Mental Illness was founded in 1979 and is the largest grassroots organization for individuals with mental illness and their families. The Web site offers support and resources, such as a national helpline, referrals for support groups, and written materials.

THROUGH THE LOOKING GLASS

www.lookingglass.org

Through the Looking Glass is an organization for families who have a child, parent, or grandparent with a disability or health issue. The center offers training, workshops, and legal services, in addition to information and resources.

MENTAL HEALTH AMERICA

www.nmha.org

Mental Health America provides advocacy, education, and research to help prevent and provide effective treatment for mental disorders.

Women with schizophrenia may stop taking their medication when they are pregnant so as to not harm their babies (Seeman, 2006). While there are no medications that are completely safe in this period, medication can make a difference with many mental illnesses, including schizophrenia, and babies fare better if they have a healthy mother who is treated for her illness (Seeman, 2006).

Health professionals who work with pregnant women with schizophrenia should be aware that some may deny being pregnant (Miller, 1990). Women who deny pregnancy ignore or misinterpret clear symptoms of pregnancy. If they feel the baby move inside their body, they may attribute this to gas. Similarly, they may rationalize their gaining weight during pregnancy as simply getting heavier. Bleeding that is associated with labor may be interpreted as the bleeding of menstruation. Denial of pregnancy is more common in women who had to relinquish care of a child in the past or who anticipate a separation from their unborn baby (Miller, 1990). It is also more common in women who are isolated, have irregular menses, are angry at the father of the baby, or fear abandonment (Friedman, Heneghan, & Rosenthal, 2007).

Other pregnant women with schizophrenia may know that they are expecting a baby but keep the pregnancy secret. They may do this because they are planning to place the child up for adoption or because they fear how others will react to their pregnancy (Friedman et al., 2007).

A prevalent problem that women with schizophrenia face after childbirth is custody loss. As many as 60% of women with schizophrenia relinquish or lose custody of their children at some point in their lives (Coverdale & Aruffo, 1989). Custody loss may be more frequent at birth, however, or in the first years after delivery (Gruenbaum &

Gammelthoft, 1993). Losing custody of a child at any time is a devastating experience and can contribute to long-standing grief, isolation, and loneliness (Apfel & Handel, 1993).

When there is custody loss or questions about risk, parenting assessment undertaken by a multidisciplinary team may help to establish (a) what the mother's parenting skills are; (b) whether her psychiatric condition is likely to stabilize, improve, or worsen over time; (c) how the illness is affecting her baby; and (d) what types of treatment could make a difference (Ostler, 2008). A diagnosis of schizophrenia, however, is not in itself an indicator of poor parenting (Nicholson, Biebel, Hinden, Henry, & Stier, 2001). Health professionals should thus be careful not to prejudge mothers with this diagnosis (or any other) as being incapable of caring for their babies without a comprehensive assessment (Seeman, 2006). Important strengths that bode well for parenting are a mother's insight into her illness (Mullick, Miller, & Jacobsen, 2001), her compliance and responsiveness to treatment, her past parenting, and the quality of her support network (Ostler, 2008).

Conclusions

HEALTH CARE VISITS provide an ideal opportunity to recognize and treat peripartum mental illness. Given that women may be reluctant to tell others about their symptoms, health professionals need to take special caution so as to recognize these disorders as soon as possible, which can lead to early treatment.

Removing barriers that contribute to symptom concealment is not easy and requires much effort by health professionals. Individual health professionals, however, can create a relationship that facilitates early detection, diagnosis, and engagement in treatment. The following are some crucial

elements of supportive approaches that can make a difference:

- Be proactive in asking a woman directly about symptoms of mental illness.
- Be sure to ask in a nonjudgmental and open-ended way (Franko, 2006).
- Know the important warning signs of peripartum mental illness.
- Be sensitive to and understanding of a woman's viewpoint and feelings so that she has the experience of being "held in mind" (Pawl, 1995).
- Acknowledge a woman's desire to be a good parent and recognize the challenges she will face in this role.
- Seek agreement so that you can communicate with other involved health professionals.
- Be kind, encouraging, available, and supportive.
- Let women know that they are not to blame for their illness.
- Engage a woman's partner or other supportive individuals in the treatment process (Murray, Cooper, Wilson, & Romaniuk, 2003).
- Be aware of your own feelings and responses toward mothers with mental illness, as those reactions can influence how you respond to these women (Eastwood, Spielvogel, & Wile, 1990).♣

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