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A classification of the main psychiatric disorders in the perinatal period

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Abstract

This work aim is to classify main psychiatric disorders in the perinatal period to the present day, highlighting their main nosographic characteristics. Moreover to show the problem of mental health during pregnancy and repercussions on the current social network, on the organizational health network and on global health.

Introduction

In order to make a nosographic classification of the main ones psychiatric disorders in the perinatal period It must first be specified some epidemiologic data such as fo example that: psychiatric pathologies can begin for the first time in the perinatal period or they can constitute a relapse of a pre-existing psychiatric condition. Moreover literature data, show an increase in the prevalence of these pathologies in developing countries when compared with the rates found in western societies [1]. Of particular interest is the increase in these pathologies in some particular groups of women, such as adolescent primiparous women, especially in developing countries [2], women undergoing voluntary termination of pregnancy [3], war veterans [4] and, finally, women with severe associated medical comorbidities, especially of the sexually transmitted type [5]. Regarding the prevalence of mood disorders and anxiety disorders, they were the most frequent psychiatric disorders in the perinatal period [6]. Psychiatric disorders emerging in this period are also represented by the use and abuse of alcohol [7] cannabis and other narcotic substances, especially methamphetamine [8], particularly in young mothers [2]..

Methods

We reviewed the literature using the latest international perinatal mental health evidence.

Results

Psychiatric disorders in the perinatal period can be classified as follows:.

Mood disorders in the perinatal period

Perinatal depression and bipolar disorder belong to this category. Many women experience mild mood swings during pregnancy or after childbirth, the so-called "Baby blues". This condition usually arise in the third- fourth postpartum day however, they resolve spontaneously within the first ten days of delivery [9]. On the contrary, a more limited share of women can develop a real episode major depressant in the ante or postnatal period in a variable percentage included respectively between 5-33% [10] and 10-15% [10]. Diagnosis was found to be greater in women in socio-economic conditions disadvantaged, in adolescent primiparas and, in general, in developing countries. Depression is classified as a perinatal one when its onset occurs during pregnancy or within the first four weeks after giving birth. However, a broader view, some literature tend to consider depression perinatal as a clinical condition comprising both major depressive episodes that minors, who can present themselves from pregnancy and then continue up to twelve months after the birth. Bipolar disorder in the perinatal period can be characterized by the presence of episodes hypomanic, more generally in type I bipolar disorder, or depressants, generally in type II bipolar disorder. Pregnancy and especially postpartum often constitute the time of onset of the disorder in the female sex [11]. The postpartum also represents a period of high risk of relapse for women already suffering from this disorder. Data of literature indicate that the risk of relapse is greater especially in the first two weeks after the birth, particularly between the second and fourth postpartum day [12].

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Anxiety disorders in the perinatal period

Anxiety disorders can occur during pregnancy or after childbirth and can be present as the only disorder or in comorbidity especially with depressive disorders. Their prevalence rates are highly variable in the perinatal period, and fluctuate in a range between 4.5% [13] and 15% [14]. In any case, anxiety disorders are more frequent than mood disorders, reaching almost twice as many cases, especially in their most severe manifestations. The most frequent anxiety disorders in the perinatal period are represented by the post-traumatic stress disorder, the generalized anxiety disorder, the obsessive compulsive disorder, and panic disorder [15] or othe specific phobias. Tocophobia which is taking on increasing importance from a clinical point of view, both for its high comorbidity with anxiety and mood disorders [16], both for its association with an increase in requests for caesarean sections in election. Generalized anxiety disorder (GAD) is usually diagnosed wherever it is present excessive anxiety and worry about daily events and activities, especially in relation to the gestational state and everything related to the child, in continuously for at least six months. Considering that certain dose of anxiety is normal in this transition to motherhood, as fundamental component of the adaptation process, we can speak of disturbance only where the symptoms reach intensity and pervasiveness such as to interfere with the normal daily functioning of the woman. Panic disorder in pregnancy is similar, from a symptomatological point of view, to the one with onset in other periods of adult life. It often occurs in comorbidity with a depressive state and it seems to arise transiently more towards the second trimester of pregnancy, in correspondence of the major physical transformations (e.g. weight gain,adaptation of the cardiovascular system) [17]. The post-traumatic stress disorder (PTSD), which in the context of psychopathology perinatal declines mainly regarding the trauma associated with the experience of childbirth, is has long been confused with a picture of postpartum depression. After the greater diffusion of studies on trauma, however, the presence of specific stimuli such as recurrent intrusive thoughts on lived birth, insomnia, hypervigilance, the implementation of avoidance behaviors towards subsequent ones pregnancies favored his correct understanding and classification as post-traumatic stress disorder [18]. Particular relevance occupies, in the context of type disorders disorder the obsessive-compulsive (DOC). During gestation, the most common obsessions they can concern contamination, with consequent cleaning compulsions or order and symmetry. In the postpartum they can become predominant, in addition to these, the obsessions related to the fear of hurting the child incidentally (ad example fear that it may slip from the hands while bathing) or voluntarily (for example throwing it through the window, wounding it in the head). Above all, this type of ideas significantly raises levels of anxiety of mothers with DOC, who recognize the irrationality and intrusiveness of such thoughts but they cannot put a limit on them and therefore they can put in place a series of avoidance behaviors compared to being in certain situations that feel like dangerous [18]. Most studies agree on an increased frequency of anxious symptoms in pregnant women compared to the postpartum. There is indeed evidence to support the fact that anxiety is more frequent and intense during gestation, while it tends to suffer a significant decrease after the birth of the baby. Specifically, anxiety levels prenatal appear higher in the first and third trimester than in the second [19] and this it was explained with reference to the psychophysical specificities of each quarter.

In the first months of pregnancy, the prevalence found concerns about 15% of pregnant women [19]; this quarter is characterized by fears and fears based on the novelty of the event, due to the appearance of the first ones bodily changes (e.g. the appearance of nausea) and the possibility that the pregnancy may not continue. Anxiety estimates in the second quarter are clear instead be lower, between 6.6% and 14% [12]. Finally, in the third quarter the prevalence is estimated between 21% and 36%: this is a time when we can witness a re-solicitation of anxieties and fears, linked to the approach of the delivery event and physical separation from the baby, as well as the anticipation of what will be the caregiving tasks [18].

Psychotic disorders in the perinatal periodd

Psychoses that occur in the perinatal period can be either affective than non-affective. The global prevalence of non-affective psychoses, of which it does schizophrenia starts, it is relatively rare. Epidemiological data reveal their rates of lifetime prevalence and incidence fluctuate between 0.30 - 0.66% and 10.2 – respectively 22.0% per hundred thousand inhabitants per year [20]. On the contrary, in the general population higher prevalence and incidence rates were detected for regarding affective psychosis [21], such as bipolar disorder with psychotic characteristics. Schizophrenia and puerperal psychosis represent the main psychotic disorders in perinatal period. The risk of relapse of schizophrenia in the first three months after giving birth it is equal to 24/25% [22] and is greater especially afterwards the abrupt suspension of psychopharmacological treatment [23]. There puerperal psychosis is a relatively rare event, when compared with the rates of postnatal depression and anxiety. It occurs in about 1-2% of cases per thousand parts e the onset is usually abrupt, more frequently within the first two weeks later childbirth. Women with a positive psychiatric history for puerperal psychosis are at high risk of relapse into subsequent pregnancies and the post-partum period is considered to be the major period risk of exacerbation of a psychotic episode throughout the puerperium [24].

Conclusions

Problem of maternal mental illness still seems difficult to accept, especially from a social point of view, and therefore this is also reflected in the organizational and management difficulties of these patients. Unfortunately, in fact, especially in Italy, unlike other European and non-European countries, motherhood is still seen as an entity characterized by an aura of mysticism and sacredness, which prevents it, even as a socio-cultural factor, from being affected from shadows and problems; which however are present and deserving, like other areas, of adequate attention and the same consideration. Antenatal services and those dedicated to protecting citizens' health should identify women who in the perinatal period present a high risk of incurring disorders Psychiatric. The prodromal symptoms must in fact be identified as soon as possible and it is therefore crucial that women are properly informed so that if they should recognize them; and they should not hesitate to request a medical consultation. It would also be good to implement prevention strategies with multidisciplinary management and implement a plan

perinatal care for women with severe mental illness, past or ongoing. Finally, these patients should be monitored closely throughout the period of pregnancy and postpartum. The problem is that in Italy, apart from rare exceptions that have specific reference centers, there is no real network of clinics or services dedicated to these problems on the national territory. This is a problem on a practical level, because these women, already in difficulty, are not even facilitated in the search for adequate psychological / psychiatric assistance and support, which can effectively respond to their needs. The prepared courses to birth, in numerous public and private institutions, are in fact currently focused, predominantly, on the preparation for childbirth of pregnant women. These courses could instead being the ideal place to also provide information and knowledge on psychological experiences that accompany parenting and perinatal mood disorders. In fact, offering information on perinatal mental health in a group context like that, could facilitate a decrease in the shame that accompanies women emotionally suffering, and also resize stigma that revolves around psychopathology in pregnancy and decrease the feeling of inadequacy that women report in these conditions. In any case, in order to face the possible negative consequences in terms of health maternal-child associated with psychiatric pathology in the perinatal period, in several countries are precise intervention protocols have already been developed and applied in clinical practice [25,26] thanks to which, in recent years, there has been a clear cut reduction of maternal mortality rates related to these pathologies [27]. In the first place it is crucial to carry out an accurate antenatal screening and identify as early as possible, in gestational age, women at risk of developing a psychiatric pathology in the perinatal period. Alongside the screening it would be useful to plan care paths domiciliary (home visiting), as already effectively in use in many countries, in order to enhance the capillarity of the interventions and the consequent identification of realities at risk that may have escaped the initial screening campaign. Finally, it would be desirable a standardization of intervention procedures and integrated management of pathologies psychiatric diseases in the perinatal period at the level of the whole national territory [18]. The high risk of dramatic consequences, such as maternal suicide, could indeed be greatly decreased if it were not for the shortage, especially in Italy, of welfare structures suitable as UMBs (Mother-Child Units). In fact, it has been hypothesized that one of the triggers for maternal suicide may be precisely the estrangement from child, which is often arranged by social workers as a form of protection for the newborn. It is therefore good, also for this reason, to evaluate each individual case in an individual and in-depth manner and train operators in a specific way. At the end we need to repot that social impact of maternal suicide is unknown. It still does not exist today in Italy such as in other countries, a real systematic surveillance system that deals with data collection on these cases. Having detailed reports on individual cases and on suicide methods, in addition to setting up information and prevention programs of suicide, could help in the ambitious goal of ending avoidable maternal deaths by 2030..

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