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Puerperal disorders

Ian Brockington

Childbearing, from the standpoint of psychological medicine, is the most complex event in human experience (Brockington, 1996). Pregnancy and childbirth involve major biological, social and emotional transitions and expose the mother to a range of psychological and medical complications. There are about 20 psychiatric disorders occurring in the post-partum period (see Table 1).

The normal puerperium

Even in favourable circumstances, mothers who have recently given birth are prone to stress, anxiety and emotional upheaval.

(a) Delivery may be followed by excitement, even elation. For many, childbirth is a key experience, though ecstatic responses are usually brief.
(b) During the first 1–2 weeks, the mother may suffer from exhaustion and physical discomfort, e.g. pelvic, perineal or mammary pain.
(c) There may be problems and worries about breast-feeding.
(d) The first few weeks often involve severe sleep deprivation.
(e) About 50% of new mothers suffer a transient phase of emotional lability or sadness a few days after parturition – the 'maternity blues'.
(f) Loss of libido is common for at least some weeks and may be troublesome and lasting. Sometimes this is due to perineal trauma, sometimes to depression. In other cases the cause is obscure.
(g) The recovery of figure and attractiveness is an issue.
(h) Changes in family dynamics may cause problems, especially the jealousy of older siblings of the new-born, but sometimes the father's jealousy of the mother's absorbing relationship with the baby.

Neuroses and adjustment reactions

Many mothers experience emotional reactions beyond normal limits.

Table 1. Post-partum psychiatric disorders

Stage of puerperium	>10%	About 1%	About 1‰	<1/10⁴
Early	Delayed onset of maternal emotional response	Grief (perinatal death) PTSD Querulant reactions Puerperal panic	Puerperal psychosis (affective, cycloid)	Neonaticide Various organic psychoses
Later	Mild post-partum depression Loss of libido	Other severe anxiety disorders Obsessions of child harm Rejection of infant Major child abuse or neglect		Psychogenic psychosis Filicide

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Post-traumatic stress disorder

Post-traumatic stress disorder (PTSD) can occur following severely painful labours. One should not underestimate the 'the nightmare of childbirth' (Bydlowski & Raoul-Duval, 1978) even with modern obstetrics. PTSD can have lasting consequences, including a phobia about childbirth (tocophobia).

Querulant reaction

If the mother feels let down by the obstetric team, she may develop a querulant reaction. Mothers may complain of mistakes, inadequate pain relief, failure to consult or 'dehumanisation' and 'humiliation' by procedures. Their preoccupation with the grievance has severe effects: at a time when the new baby and family demand all their attention, their minds are filled with bitter recriminations and vengeful fantasies.

Puerperal panic

Some mothers develop acute anxiety when they return home and are confronted by their responsibilities for a fragile and vulnerable new baby. This can lead to disorganised thinking, insomnia and phobic avoidance (De Armond, 1954). It occurs particularly in first-time mothers, living in isolated 'nuclear' families. Difficulties can be avoided if a competent grandmother or other family member is at hand.

Pathological fear of cot death

Anxiety about the child is an inescapable aspect of motherhood, but is sometimes extreme, often focused on the remote possibility of sudden infant death. There are mothers who are afraid to let their infants sleep in case they stop breathing, check the infant many times every night, or wake them, to ensure they are alive. These mothers experience severe insomnia and become exhausted.

Generalised anxiety

Even without the specific components of puerperal panic and fear of sudden infant death, the care of an infant involves constant vigilance. Moll (1920) described 'maternity neurosis', with anxieties about the baby's growth and development, excessive solicitude and sensitivity to the slightest indication of illness and the fear that simple tasks (like bathing) put the baby at risk. In some mothers, the anxieties resemble a hypochondriacal neurosis.

Phobia about the infant

A mother who suffers from excessive anxiety, whatever the cause, may develop a phobic avoidance of her infant (Sved-Williams, 1992).

Obsessional neurosis

Obsessional neurosis in mothers who have recently given birth may involve infanticidal impulses (Chapman, 1959; Button & Reivich, 1972). These mothers imagine themselves running amok and harming their babies; they anticipate the horror of their relatives and newspaper headlines reporting the gruesome acts. They avoid being left alone with their children, and sometimes take extraordinary precautions to prevent themselves from carrying out the impulse. Obsessions may also have the content of child sexual abuse.

Grief

About 1% of mothers suffer the trauma of infant loss from perinatal death. Others give birth to babies with congenital abnormalities or learning difficulties. Two or three in 1000 mothers suffer the trauma of sudden infant death syndrome. All these mothers suffer severe grief, which varies depending on the circumstances, with differing degrees of shock, denial, emotional numbness, guilt and recrimination (Smialek, 1978; Condon, 1986). There are the crises of facing friends, relatives and other mothers with healthy babies; the disposal of toys, baby clothes and nursery furniture; and difficulties with surviving children, who are also affected by the loss. After sudden infant death there is also a harrowing forensic investigation.

Treatment

The diagnosis and general therapeutic approach is described below, under post-partum depression. In addition, these disorders require specific psychological treatments, generally some form of cognitive–behavioural psychotherapy.

Mother–infant relationship disorders

The development of the relationship with the newborn is the most important dynamic process in the puerperium. This is popularly known as 'bonding',

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though this term misses the essence – the mother's feelings about the infant. This relationship starts during pregnancy (pre-partum bonding; Cranley, 1981). Mothers usually talk to the infant within, and actively rehearse in fantasy caring for the infant. However, this stage may be poorly developed (Cohen, 1988), especially when the pregnancy is rejected; there may even be foetal abuse (Condon, 1987).

After delivery, it is common for mothers to experience difficulty in adjusting to the new baby. They may be exhausted and unwell. Some infants eat and sleep poorly, or scream inconsolably for hours, and some (those born prematurely or with disabilities) have delayed social development. Perhaps 10–15% of mothers experience a delay in their emotional response. They may be distressed by the absence of maternal feelings and may say the baby does not seem to be their own. Some seek reassurance from their own mothers or confidantes, but others conceal their feelings. Shame is an important reason why these disorders escape attention. Midwives and primary care teams should be aware of this hidden cause of post-partum depression, especially because these mothers are so easily treated. They require sympathetic understanding and explanation of the way relationships develop – as the baby begins to gaze at its mother, smile and laugh, maternal feelings rapidly reach their full strength.

Rejection

In a small minority (perhaps 1–2%) this abnormal response is prolonged and severe, amounting to rejection of the infant – covert or overt. A mother may try to persuade her own mother, or another relative, to take over. She may demand that the infant is fostered or adopted. One of the hallmarks of rejection is improvement when away from the baby; the main clue may be the attempt to escape. The most poignant manifestation is the secret wish that the baby 'disappear'; some mothers have the courage or desperation to make these wishes explicit. Rejection of children has been recognised by child psychiatrists for decades, but the early stages have been neglected. This form of psychopathology, which affects at least 20% of mothers presenting with postnatal depression, is poorly recognised by general practitioners (GPs) and even psychiatrists. This is surprising because these disorders are a major part of the work of post-partum mental health teams. It is these symptoms which probably have the most severe effect on family life and the children.

Management (Brockington, 1996) begins with the decision whether or not to attempt treatment. Not all women are maternal, and the child has no need to be reared by its birth mother. Where there is open rejection the option of relinquishment must be acknowledged and discussed with both parents. Usually these mothers wish to overcome the problem. Since almost all are depressed, antidepressant treatment is given, through psychotherapy and drugs or electroconvulsive therapy (ECT). This is sometimes sufficient, but often not. The specific therapy is working on the dyadic relationship. It is useless to separate mother and baby, which merely postpones the problem and introduces an element of avoidance. The baby alone has the power to awaken its mother's feelings. The mother–infant relationship does not differ radically from other relationships, which grow through shared pleasure, and the essence of treatment is to create the circumstances in which mother and child can enjoy each other. There are two elements in this – protecting her from the irksome burden of care, and fostering positive interactions. If there has been any hint of abuse, or if she is troubled by aggressive impulses, she must never be left alone with her infant. However, when the baby is calm and content, and the mother also feels at ease, she should be encouraged to interact – to cuddle, talk to and play with the infant. Interventions such as baby massage, mother and infant bathing and play therapy can be used. Once the mother begins to enjoy the interaction, lasting cure is not far away. This effect can be achieved at home, provided there is enough support to relieve the mother of stressful duties. Sometimes, the grandmother is able and willing to take on this role; many a young mother has been patiently guided and shielded by her own mother and has overcome rejection without the need for professional help. A family group or an understanding partner can do the same. It is helpful to involve mothers who have recovered – living proof of the possibility of recovery. Day hospital treatment is highly appropriate. In the most severe and refractory cases, the proper setting is an in-patient mother and baby unit. The success rate is high. This is a rewarding area of psychiatry, because much can be achieved by skilled guidance and specific psychotherapies, which is of lasting and fundamental importance to the family.

Child abuse

Pathological anger is a crucial feature of a disordered mother–infant relationship. Loss of control is often first expressed by shouting at the baby. As a precursor of more serious assaults, a mother may handle the baby roughly or throw it into the cot. An urge to shake a crying baby, which risks causing subdural bleeding, is common. She may have

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impulses to strangle or suffocate the child, or throw it on the floor or against a wall. Aggression, cruelty and neglect take many forms – shaking, wrenching the limbs, beatings, bites, burns, asphyxiation, poisoning, starvation and sequestration (Tardieu, 1860). The term Munchausen's syndrome by proxy (Meadow, 1977) is applied to mothers who pretend their child is ill, or deliberately induce illness to get medical attention. Three to six per 1000 infants are severely abused (Baldwin & Oliver, 1975). The risk of recurrence is much higher when abuse has already occurred, and such mothers should be supervised, until the underlying problem has been thoroughly assessed and treated.

Social services have a key and statutory role in child protection, and must be involved, with or without the NSPCC (National Society for the Prevention of Cruelty to Children). Social workers have greater experience and more resources than psychiatric or primary care teams for dealing with the practical difficulties of mothering. Their case conferences recruit and organise resources for supporting the mother. They can arrange home help and day nurseries. Their family centres fulfil a similar function to a mother and baby day hospital. *In extremis*, they can safeguard the child by providing emergency foster care, voluntarily or under various sections of the Children Act 1989.

Infanticide

This extreme manifestation occurs in a variety of settings – neonaticide (customary and anomic), child abuse, depression, various psychoses and trance states. It is important to remember that a deeply depressed, suicidal mother is a risk to her child, and this is another indication for insisting that a responsible adult is always present.

Post-partum depression

Although all humans are prone to depression, it is relatively common in women during the reproductive years. Depression is only slightly more common in newly delivered mothers than in other mothers or pregnant women, but it can have serious effects on the developing child and family. A few women develop recurrent post-partum melancholia, a disorder related to puerperal psychosis. The term post-partum (or postnatal) depression was introduced within the past 40 years, as psychiatrists turned from psychosis to milder, more common disorders. Depression after childbirth is clinically similar to any other depression. It is more frequent in surveys than medical consultations. Case register studies show that the number of mothers admitted to hospital is low, less than 1% of all mothers delivered (Kendell *et al*, 1987). About 5% of mothers turn to their GP for help – far fewer than the figures found in surveys. Of the 40–50 surveys published during the past 30 years, most report depression in 10–20% of mothers. The most extensive, involving 483 women in Oxford, showed a point prevalence of 8.7% three months after delivery, and a new episode rate of 7.7% within the first three months and 7.4% in the next nine months (Cooper *et al*, 1988).

The concept of postnatal depression has been valuable in bringing the psychiatric complications of childbirth to public awareness, providing an explanation for mothers' distress and role failure, diminishing stigma, enabling mothers to accept that they are ill and come forward for treatment, and even giving a partial explanation for child abuse, neglect and infanticide. It has helped to arouse concern about an important public health problem. On the other hand it carries the danger of oversimplification, suggesting a homogeneous disorder, which can be investigated and treated as a single entity with a common cause. Almost all mothers with anxiety, obsessional or post-traumatic disorders, or with a disturbed infant relationship, are depressed, but the setting, causes and treatment are different.

Diagnosis

The first requirement is early and accurate diagnosis. Midwives and the primary care team – health visitors during their visits, and the GP at the six-week examination – are well placed to diagnose early puerperal disorders. The Edinburgh Postnatal Depression Scale (EPDS; Cox *et al*, 1987) is a sensitive and specific screening instrument for depression.

Once a problem has been identified, the mother needs a full psychiatric examination, exploring the symptoms and course of the illness, and its setting in the context of her life history, personality and circumstances. One must explore her relationships with spouse, baby, other children and family of origin. It is important to establish what supports are available, and the factors contributing to her vulnerability. If possible these facts should be verified with an informant. All this is standard psychiatric practice. In addition, one must review the course of the pregnancy, stage by stage: the circumstances of conception; attitudes to pregnancy and motherhood; the experience of parturition; mental health throughout the pre- and post-

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partum period; and the effects of this process on relationships, especially with the infant. A home visit has a particular value, not only because mothers, fettered by family responsibilities, find it difficult to travel to out-patient clinics, but because the mother is seen in her own environment. There is a quality to home assessment which cannot be matched in a doctor's office. Afterwards, further consultations may have to be held at the clinic because of time restraints; if ongoing care can be provided at home, by medical or community nursing staff, it is an advantage.

Principles of therapy

Both the disorder and any underlying vulnerabilities must be treated. This treatment will always involve psychotherapy, if only in the form of a single interview, and sometimes drugs or other specific treatments.

The psychotherapeutic approach begins with a thorough, probing but empathic exploration of the mother's experiences. For the first time she may share the wounds of childhood trauma, tormenting self-reproach and contemporary burdens with a sympathetic counsellor. This especially applies to shameful feelings she may have about her baby, which few members of the public could hear without shock or censure. There is an opportunity to explain that these experiences are widespread, though too often faced in loneliness and silence by mothers, who do not know that they are understandable and can be remedied. It is an enormous relief to mothers to hear that others have, with help, been able to overcome them.

After this preliminary therapeutic interaction, the next stage will often be more psychotherapy; but since the GP or psychiatrist is constrained by the demands of other assessments, this often involves finding an alternative source of continuing support. This may be provided by nursing staff in various settings, for example, day hospital or home visits. Sometimes other professionals, such as health visitors, have a particular opportunity to help. Prolonged 'dynamic' exploration is indicated only in mothers with intractable neurotic conflicts; these tend to emerge later, when depression fails to remit. The pioneers, Richard and Katherine Gordon of New Jersey, made a important contribution, in deflecting attention from these techniques to approaches specifically addressing the problems of motherhood and maternal skills.

It is well to remember that most mothers receive psychotherapy from friends, their own mother or their partner. Often the role of the professional is to support these supporters. Working with the baby's father is important, though is often difficult to achieve because of his unavailability or unwillingness. The partner is potentially the main supporter, and his failings are often instrumental in the mother's demoralisation. When interviewing fathers, it is important to bear in mind the danger of aggravating conflict, unless the approach is even-handed and impartial.

Many mothers require antidepressant drug treatment. There is no evidence that any drug is superior to others in post-partum depression, but it might be wise to use agents whose safety has been established by long usage. The risks to a breast-fed infant appear minimal, since the infant receives only a tiny dose. ECT is rapidly effective in some severe depressions. The role of hormonal treatments, such as oestrogen and progesterone, is not yet agreed.

Prevention

Gordon & Gordon (1959) studied prevention in the 1950s. Their approach was educational – instruction on the social and psychological adjustment to parenthood. They carried out a controlled study of this approach, which established the value of antenatal classes. Prevention has a particular importance in mothers who have previously suffered from severe or prolonged post-partum depression. If these mothers are symptomatic during pregnancy, or have obvious risk factors, such as marital friction or social isolation, they will need support from community psychiatric nurses, voluntary agencies or groups. If they are well, the most that can be done is to maintain contact, and start treatment early in the event of a recurrence. Prophylactic antidepressant medication should be considered; because post-partum depression usually starts after a delay, it is best to begin after parturition, to avoid exposing the foetus to drugs unnecessarily.

Post-partum psychoses

The psychotic complications of childbirth can be divided into three groups – organic psychoses, psychogenic psychoses and affective or cycloid psychoses.

The organic group all begin early in the puerperium. They are rare in modern obstetric practice. Some are extremely rare – the idiopathic confusional states of labour (Kirchberg, 1913) continuing or starting after delivery, exhaustion to the point of catatonic stupor and delirium tremens; but two may still be significant in the developing world, wherever

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birth rates are high and obstetric care is lacking.

(a) Post-eclamptic psychosis (Olshausen, 1891). This follows about 5% of cases of eclampsia. It is usually confusional in form, but may be manic. There may be a gap between the last fit and onset.

(b) Infective delirium, associated with septic metritis or breast abscess.

Psychogenic psychoses are also rare. They include the post-partum onset of morbid jealousy, which can also occur during pregnancy, promoted by the disturbance of sexual life which may result from pregnancy and childbirth. Occasionally, more complex reactive psychoses develop in response to severe stress; they are similar to the reactive psychoses occasionally described in adoptive mothers and in fathers after childbirth.

The common form of post-partum psychosis (often termed puerperal psychosis; Osiander, 1797; Esquirol, 1818; Marcé, 1858) takes the form of:

(a) Mania.

(b) Depression, with delusions, confusion, stupor or other psychotic features.

(c) A pleomorphic cycloid (schizophreniform, schizoaffective) psychosis. The term post-partum affective psychosis, used in the USA, ignores extensive literature on this variety.

This disorder has the following features:

(a) It affects about 1/1000 mothers (Kendell *et al*, 1987).
  (i) It is more common in *primipara* (relative risk 2).
  (ii) The risk in women with manic depression is much higher (Reich & Winokur, 1970).
  (iii) It may be more common in mothers treated with bromocriptine and possibly steroids.

(b) It usually begins between the 3rd and 14th day, somewhat later when depressive in form.

(c) Without therapy, duration is 6–8 months, with modern therapy 1–3 months. There may be relapses, especially post-psychotic depression.

(d) There are recurrences, with a risk of one-fifth to one-third with each subsequent pregnancy.

(e) About 50% of patients suffer non-puerperal episodes; they have a higher risk of post-partum recurrences, approaching 100%.

(f) There is often a family history of psychiatric illness.

Causes

There is much evidence that this group of illnesses is related to manic–depressive psychosis. When considering the aetiology, some of the questions – the nature of the diathesis, and the determinants of clinical polarity – belong to the larger study of bipolar disorder. The specific element concerns the triggers which provoke an episode. The clinical data suggest several pregnancy-related triggers.

(a) Abortion – episodes occur after miscarriage, termination, possibly trophoblastic tumours, in susceptible women prone to puerperal, bipolar or cycloid disorders.

(b) Pregnancy itself (pre-partum psychosis) – susceptible women are prone to episodes beginning in late pregnancy.

(c) The early puerperium, especially the first 10 days (the main trigger, one of the most potent in psychiatry).

(d) Post-partum menstruation – a small minority of mothers relapse in rhythm with menstruation.

(e) Menstruation in general – there is an extensive literature on 'menstrual psychosis' (Krafft-Ebing, 1902), whose clinical features resemble puerperal psychosis. The association of menstrual and puerperal psychosis has been noted at least 20 times, and directs attention to the interactions between reproductive hormones and the central nervous system.

(f) Weaning – there is weaker evidence that the cessation of lactation can trigger episodes.

These triggers need to be considered in relation to other triggers of bipolar episodes, including steroid treatment, surgery and seasonal climatic changes. There are associations between all these symptomatic psychoses and puerperal psychosis.

Treatment

Puerperal psychosis can lead to the most severe disturbances seen in psychiatry, and many patients have languished in asylums, exposed to infection and out of touch with their infants and families. Even in the 19th century, thoughtful clinicians urged that it be treated at home. There, the patient could maintain her role as wife, homemaker and mother to other children, develop her relationship with the new-born baby and even continue breast-feeding. Oates (1988) has recently re-emphasised the importance and feasibility of home treatment, in partnership with effective family support and the primary care team. When treating a patient at home, one must guard against suicide and filicide. If hospital admission is necessary, there are great advantages in joint mother and baby admission.

The primary pharmaceutical need is for sedation, and most receive powerful neuroleptics; but these mothers often suffer severe extrapyramidal side-

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effects, even neuroleptic malignant syndrome. It has been suggested that the newer neuroleptics are more appropriate, though it is too early to reach any conclusions. Lithium has been used increasingly since the link with manic depressive psychosis was recognised; it is safe in the puerperium, although one breast-fed infant developed side-effects. There is growing evidence for its prophylactic value, although a double-blind prospective treatment trial has not yet been completed. The remarkable efficacy of ECT in all clinical varieties of puerperal psychosis was recognised as soon as this treatment was introduced. Hormones have been used speculatively: there is no conclusive evidence for their effect, either in therapy or prophylaxis.

Services

Maternal mental health is neglected, and there is a need to improve clinical practice and services. In family life, the mother is the focus; all members benefit from her devotion, enthusiasm and resourcefulness, and all – especially the children – suffer from her discouragement. Every effort made to improve her well-being and morale is a contribution to the health of the next generation. The shape of the ideal service is slowly emerging. It includes the following.

Specialist multi-disciplinary team

This team is capable of treating severe and intractable illness, and undertaking training and research; specialists can also deal with the complexities of medico-legal assessment.

Community service

The service should have an 'outreach' providing domiciliary assessment and home treatment.

Day hospital

This offers a rich programme of support, including contact with other mothers with similar difficulties. There are group discussions as well as one-to-one psychotherapy. The programme includes specific therapies such as play therapy, anxiety management, motherhood classes, occupational and drama therapy. The problems of distance can be overcome by using taxis; toddlers can play in a crèche, supervised by nursery nurses.

In-patient facilities

There must be facilities for conjoint admission (Main, 1958). Most mothers with psychiatric illness should not be separated from their infants; separation is distressing and compounds the problems for them and their families. It is only advisable when the mother is a danger to her infant – even then the presence of a competent adult is a safeguard. Conjoint admission can be provided on general psychiatry wards serving areas with populations less than 500 000; for large cities and conurbations, it is more effective and safer to use wards designated for mothers; these provide an ideal milieu. The requirement is estimated at eight beds per million total population.

Obstetric liaison service

An obstetric liaison service capable of detecting illness and vulnerability during pregnancy should be available.

Links with other agencies

It is important to forge links with other agencies, especially social services, which provide services for mothers.

Voluntary organisations

It is also important to link with a network of voluntary organisations working independently, but with close ties with the professional service. The goal is to provide both professional and voluntary help to all who require it.

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Multiple choice questions

1. Clinically significant psychiatric disorders, which occur in about 10% of recently delivered mothers include:
   a depression
   b obsessions of infanticide
   c delayed maternal emotional response
   d loss of libido
   e PTSD.

2. Psychiatric disorders specific to the early puerperium include:
   a neonaticide
   b querulant reactions
   c mother–infant relationship ('bonding') disorders
   d filicide
   e cycloid psychosis.

3. The following are essential in the investigation of a post-partum psychiatric disorder:
   a reviewing the events of pregnancy and parturition
   b interviewing the husband/partner
   c dynamic exploration of the mother's relationship to her own mother
   d exploration of her feelings about the infant
   e completion of the EPDS.

4. In the treatment of a mother–infant relationship disorder:
   a it is necessary to separate mother and baby
   b ECT is the treatment of choice
   c in most cases antidepressive drugs are not indicated
   d in addition to antidepressive therapy, therapeutic work on mother–child interaction is usually required
   e conjoint admission of mother and infant is indicated.

5. In the following circumstances, a mother should not be left alone with her baby:
   a she is responsible for child abuse and has not yet been assessed and treated
   b she is suffering from puerperal psychosis
   c she has obsessions of child sexual abuse
   d she is actively suicidal
   e the baby's difficult temperament makes her feel angry and rejecting.

MCQ answers

1	2	3	4	5
a T	a T	a T	a F	a T
b F	b F	b F	b F	b F
c T	c T	c F	c F	c F
d T	d F	d T	d T	d T
e F	e F	e F	e F	e T

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