

**Original Article**

## Pattern of Psychiatric Disorders in Postpartum Women attending Obstetrics and Gynaecology OPD of M.M.Medical College & Hospital, Kumarhatti, Solan(H.P.) India

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**Abstract**

**Introduction:** *Pregnancy is the most beautiful and memorable time in a woman's life. Pregnancy is considered as a period of increased vulnerability to psychiatric disorders. Psychiatric disorders during pregnancy are associated with poor maternal health and inadequate prenatal care. Maternal psychiatric disorders during pregnancy and the postpartum period are also associated with numerous adverse outcomes for the offspring, including maladaptive fetal growth and development, poor cognitive development and behavior during childhood and adolescence, and negative nutritional and health effects. This study was done to examine the pattern and severity of psychiatric disorders in 100 antepartum women attending Obstetrics & Gynaecology OPD of MMMC & H, Kumarhatti, Solan.*

**Material and Methods:** *Two scales, the BPRS and HAM-D were applied on the patients. The Brief Psychiatric Rating Scale (BPRS) rating scale is used to measure psychiatric symptoms such as, anxiety, depression, hallucinations and unusual behaviour. The Hamilton Rating Scale for Depression (HRSD), also called the Hamilton Depression Rating Scale (HAM-D) gives an indication of depression.*

**Results:** *Pattern of psychiatric disorders, according to BPRS showed, prevalence of anxiety (10%), tension (9%), depressed mood (11%), somatic concern (5%), guilt feeling (2%), emotional withdrawal (1%). Out of the 100 antenatal females, HAM-D scale showed three females with mild depression {8-13 score range}, eight with moderate depression {14-18 score range} and none with severe depression {19-22 score range}.*

**Conclusion:** *The study showed that psychiatric disorders are not uncommon in postnatal women and need to be looked into for their better diagnosis & management*

**Keywords:** *Pregnancy, Postpartum, Anxiety, Depression, Psychiatric Disorders.*

**Introduction**

Pregnancy is the most beautiful and memorable time in a woman's life. Apart from medical and

obstetrical challenges it involves a of lot emotional, psychological and social aspects too. Although women having medical and obstetrical

problems commonly seek treatment, psychological problems are often not taken into consideration. A female may have emotional disturbances and may attribute these changes to changes in hormone levels. Psychiatric disorders if untreated can disrupt the social life and can have undesirable effects on fetal and neonatal development, so it is important to identify women at risk for developing psychiatric problems during pregnancy and postpartum and initiate timely treatment. Mood disorders are more common in women as compared to men and the prevalence increases during childbearing years<sup>1</sup>. Though pregnancy has traditionally been considered a time of emotional well-being for women, conferring protection against psychiatric disorders, studies describe rates of minor and major depression to be approximately 14-20%.<sup>2,3</sup> Bipolar disorder patients are at high risk of relapse of symptoms during the pregnancy<sup>4,5</sup>, and early postpartum period<sup>6,7</sup>. The risk of relapse during pregnancy has been estimated to be 50% or more<sup>4,5</sup>. Women suffering with schizophrenia are more likely to have unplanned pregnancies<sup>8</sup>, and have lowest risk for psychosis in the first six months postpartum, compared with women diagnosed with other functional psychoses<sup>9</sup>. A study conducted by B Vythilingum, in 2009<sup>10</sup>, reached the conclusion that anxiety disorders are common during pregnancy and after childbirth. Women with perinatal anxiety commonly present with excessive concerns about the pregnancy, foetus or infant<sup>10</sup>. Results on incidence, course and patterns of perinatal mental disorders vary widely, as was reported by Martini J et al in 2015<sup>11</sup>. This study was performed to determine the pattern and severity of psychiatric disorders in postpartum patients attending Obstetrics & Gynaecology OPD of M.M. Medical College & Hospital, Kumarhatti, Solan(H.P.) India.

### Material and Methods

An observational survey based study was conducted in the Obstetrics & Gynaecology OPD, by a close ended questionnaire BPRS and HAM-

D Scale. 100 postpartum females were enrolled in the study keeping in mind the below mentioned inclusion and exclusion criteria.

The Brief Psychiatric Rating Scale (BPRS) is a rating scale which a clinician or researcher may use to measure psychiatric symptoms such as depression, anxiety, hallucinations and unusual behaviour. Each symptom is rated 1-7.

The Hamilton Rating Scale for Depression (HRSD), also called the Hamilton Depression Rating Scale (HDRS), abbreviated HAM-D, is a multiple item questionnaire which is used to provide an indication of depression, and it is also used as a guide to evaluate recovery.

**Inclusion criteria** - Age between 18–45 years.

**Exclusion criteria** - Women with previous history of psychiatric disorder.

S.No	Age	No. of Patients
1	15-20	4
2	21-25	36
3	26-30	39
4	31-35	16
5	36-40	5

### Results

In the study, 100 postpartum females were enrolled and in all the 100 postpartum females HAM-D and BPRS Scales were applied. These females were evaluated clinically. The results of the BPRS Scale that was applied first are shown below.

Brief psychiatric rating scale (BPRS)

The scale used the following ranges for each criterion assessed.

0 = Not assessed, 1 = Not present, 2 = Very mild, 3 = Mild, 4 = Moderate, 5 = Moderately severe, 6 = Severe, 7 = Extremely severe

**1. Somatic concern:** 5(5%), showed positive response for this criterion, which assesses preoccupation with physical health, hypochondriasis and fear of physical illness. Out of these five, one showed mild {3}, three showed moderate {4}, and one showed moderately severe {5} symptom grade.

**2. Anxiety:** 10(10%), showed positive response for this criterion, and it assesses over-concern for present or future, fear, worry and uneasiness.

**3. Emotional withdrawal:** 1(1%), showed positive response for this criterion, which assesses lack of spontaneous interaction, isolation and deficiency in relating to others. This patient showed moderate {4} level of symptom grade.

**4. Conceptual disorganization:** This assesses thought processes which may be confused, disconnected, disorganized or disrupted. No patient responded positively to this.

**5. Guilt feelings:** 2 (2%) showed positive response this criterion, which assesses self-blame, shame, remorse for past behaviour. One showed moderate {4} and one showed moderately severe {5} symptom grade.

**6. Tension:** 9 {9%} showed positive response to this criterion, which assesses physical and motor manifestations of nervousness and over-activation. Out of these eight, five showed mild {3}, three showed moderate {4} and one showed moderately severe {5} symptom grade.

**7. Mannerisms and posturing:** This assesses peculiar, bizarre, unnatural motor behaviour (not including tic). No patient responded positively to this.

**8. Grandiosity:** This assesses exaggerated self-opinion, arrogance, conviction of unusual power or abilities. No patient responded positively to this.

**9. Depressive mood:** 11{11%}, responded positively to this item, which assesses sorrow, sadness, despondency and pessimism. Out of the eleven, three had mild {3}, eight had moderate {4}, and none had moderately severe {5} symptom grade.

**10. Hostility:** This item assesses animosity, contempt, belligerence, and disdain for others. No patient responded affirmatively to this.

**11. Suspiciousness:** 1(1%), showed positive response for this criterion, This item assesses mistrust and or belief that others harbour malicious or discriminatory intent. The severity was moderately severe {5}.

**12. Hallucinatory behavior:** 1(1%), showed positive response for this criterion. This item assesses perceptions without normal external

stimulus correspondence. The grading was moderate {4}.

**13. Motor retardation:** 1(1%), showed positive response for this criterion .This item assesses slowed, weakened movements or speech and or reduced body tone. The grading was found to be very mild {2}.

**14. Uncooperativeness:** 1(1%), showed positive response for this criterion .This item assesses resistance, guardedness and or rejection of authority. The grading showed it to be moderate {4}.

**15. Unusual thought content:** 1(1%), showed positive response for this criterion and grading revealed moderately severe {5}. This item assesses unusual, odd, strange, bizarre thought content.

**16. Blunted affect:** 1(1%), responded positively to this and grading was found to be very mild {2}This item assesses reduced emotional tone, reduction in formal intensity of feelings and or flatness.

**17. Excitement:** This item assesses heightened emotional tone, agitation and or increased reactivity. No patient responded positively to this.

**18. Disorientation:** This item assesses confusion or lack of proper association for person, place or time. No patient responded positively to this.

Hamilton depression rating scale (HAM-D)

The HAM-D is designed to rate the severity of depression in patients. Although it contains 21 areas, we calculate the patient's score on the first 17 answers.

Scoring is as follows:

0 - 7 = Normal

8 - 13 = Mild Depression

14-18 = Moderate Depression

19 - 22 = Severe Depression

> 23 = Very Severe Depression

Out of the 100 postnatal females, three showed mild depression {8-13 score range}, eight showed moderate depression {14-18 score range} and none showed severe {19-22 score range}.

## Discussion

All new mothers are somewhat anxious. Being a mother is a new role, a new job, with a new person in your life and new responsibilities. All the women in this study were studied when they had come for vaccination of their child and were not aware about their mental health status. The traditional view that there are three postpartum psychiatric disorders—the maternity blues, puerperal psychosis, and postnatal depression—is an over simplification. The range of disorders is wide. This study focuses on those important to general psychiatrists and family practitioners. It does cover mild disorders that require no treatment (such as the maternity blues), nor grieving over fetal loss, nor rare complications (such as organic psychoses), nor the effect of childbirth on eating disorders. In this study we found that the prevalence rate of depression was 11%. Heron et al did meta-analysis of 59 studies and estimated that the average prevalence rate of post natal depression was 13%<sup>12</sup>. After doing logistic regression analysis strongest predictors identified were pregnancy related factors like multigravida, feeling tense during pregnancy, having girl child, history of miscarriage, and women who were not able to confide in their partner<sup>13</sup>. In the perinatal period new onset psychosis is a rare. The prevalence of postpartum psychosis has been reported as approximately 1 to 2 per 1000 live births. This condition usually manifests within 3 months postpartum, and new onset psychosis should be considered as a medical and obstetrical emergency<sup>18</sup>. Only one of our patients had hallucinatory behavior. In our study, the prevalence of anxiety disorders as a whole was found to be 10%, which is slightly lower than the findings of Heron et al.<sup>12</sup>, who, in a large community sample of pregnant women, found that 21% had clinically significant anxiety symptoms and, of these, 64% continued to have anxiety in postpartum<sup>12</sup>. Anxiety and depression often occur together, are often present in pregnancy and persist if not treated<sup>13</sup>. GAD, persistent and excessive worry of more than 6 months duration,

may be more common in postnatal women than in the general population<sup>14</sup>. Studies suggest that postpartum anxiety disorders are under emphasised and are more common than depression<sup>19,20</sup>. There is some evidence that severe postpartum anxiety has adverse effects on the child, with a high proportion of insecure and disorganised attachments<sup>21</sup>.

## Conclusion

To conclude, this study provides useful information about the prevalence of psychiatric disorders and risk factors especially the role of socio-cultural environment and practices prevalent in the North Indian region. Since socio-cultural factors play a important role in causation of psychiatric disorders, these should be aimed for. People still consider a girl child a liability. Efforts to improve the condition of women by identifying the loopholes and measures to make them independent both emotionally economically and such as higher literacy and improved socio-economic status warrant further research. Further, more effective measures such as appointment of counselors, at the level of health care setting, to screen and counseling for psychaitric disorders are needed. This will improve quality of care required under National Rural Health Mission to reduce maternal morbidity due to neglect and depression.

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**Conflict of Interest:** None

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