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Postpartum Psychopathological Disorders

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Authors' contributions

This work was carried out in collaboration between both authors. Both authors read and approved the final manuscript.

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ABSTRACT

Pregnancy and the postpartum period are times of psychological vulnerability. The postpartum period is particularly prone to complications. The objective of this article is to provide an overview of psychopathological disorders during the postpartum period.

Keywords: Pregnancy; psychological vulnerability; childbirth; gravido-puerperal period.

1. INTRODUCTION

The gravido-puerperal period, including pregnancy, childbirth, and the postpartum period, is accompanied by a restructuring and psychological vulnerability that can alter maternal mental health [1] and lead to significant psychiatric disorders more frequently encountered in the postpartum period [2-3]. In Algeria, the epidemiological situation of these disorders remains poorly understood and unexplored to this day, as no study has been conducted or published on this topic.

The objectives of this article are:

- To provide an overview of the main psychopathological disorders during the postpartum period, ranging from minor forms corresponding to baby blues, to

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major forms related to depression and psychosis.
- To report the results of a study conducted in Ouargla on postpartum depression.

2. THE MAIN PSYCHOPATHOLOGICAL DISORDERS

2.1 Baby blues or Postpartum Blues

Epidemiology:

Postpartum blues affects 50 to 80% of women who have given birth. [4]

Main characteristics:

It is a transient, acute, and benign syndrome that occurs between the 3rd and 10th day after delivery. [5,6]

It typically lasts for about 24 hours and can last up to 4-5 days.

It is characterized by crying, irritability, emotional lability, dysphoria, sleep disturbances, fatigue, and anxiety.

Episodes of crying, sensitivity, and fear of being neglected are often associated with an obsessive idea of not knowing how to take care of the baby. [7,8,9]

This very common condition is not pathological; only the severity of postpartum blues or the persistence of symptoms after the first week may warrant a consultation to screen for possible postpartum depression. Therefore, it is important to screen for baby blues and monitor it closely [7].

Treatment:

Postpartum blues does not require medication treatment. The relationship with healthcare providers, the valorization of the mother's maternal functions, mobilization of the support network, information, a warm and understanding attitude are usually sufficient to get through a phase that is considered non-pathological or even physiological.

2.2 Postpartum Depression

Epidemiology:

Its prevalence is estimated to be between 10 and 20%, making it a major public health problem worldwide [2,7,10,11].

In Algeria, a study conducted in the Ouargla district reported a prevalence of 24% [12].

Main characteristics:

Postpartum depression can either prolong postpartum blues or occur in the weeks following childbirth [13,14,15].

The characteristic features of postpartum depression include: [16,17]

- Major exhaustion with sleep disorders such as insomnia and nightmares.
- Impulse phobias with fears of harming the baby and loss of interest in the child.
- Irritability towards the partner or other children.
- Intense and frequent anxiety, intrusive self-accusations, and unfounded worries about the baby's health.
- Panic attacks.
- Guilt for not deriving joy from motherhood; devaluation of one's maternal abilities.
- Somatic complaints: pain, discomfort, fatigue, but also decreased libido.

Treatment:

Early outpatient management is often sufficient. Patients should receive supportive psychotherapy combined with antidepressant medication (serotonin reuptake inhibitor) in specialized consultation.
It is important to:

- Take into account their desire to breastfeed and support them in their choice.
- Monitor the onset of dark and suicidal thoughts.
- Consider hospitalization if necessary, preferably in a specialized unit.
- Inform caregivers and encourage them to provide the best possible support to the postpartum woman.

2.3 Postpartum Confusional Psychosis

Epidemiology:

This is the least common mental disorder during the postpartum period, affecting 1 to 2 births per 1000, but it is the most dangerous for both the mother and the baby [18].

Table 1. Differences between postpartum depression and non-prenatal depression [17]

Postpartum depression	Ordinary depression
Symptomatic aggravation in the evening	Symptomatic improvement in the evening
Difficulty falling asleep	Early morning awakenings
Emotional lability	Stable mood
Rare suicidal thoughts	Fairly frequent suicidal thoughts
Loss of esteem for maternal abilities	Loss of self-esteem
Frequent anxiety directed towards the baby	Less frequent anxiety
Rare psychomotor retardation	Frequent psychomotor retardation

Table 2. Comparison between postpartum blues, postpartum psychosis, and postpartum depression [21]

	Postpartum blues	**Psychoses puerperal**	**Postpartum depression**
Begeninig	Within 2 to 3 days postpartum	Within the first 4 weeks, with a peak frequency at day 10	Within the first 4 weeks, can last up to one year postpartum.
Duration	< 7 days	Variable, often an acute episode.	> 2 weeks
Prevalence	50 to 80%		17.22% in the global population.
Symptoms	Crying, irritability, Emotional lability, Sleep disturbances, Fatigue and anxiety. Susceptibility Fear of being neglected	Clouding of consciousness. Temporal-spatial disorientation. Polymorphic delusion. Great fluctuation in mood.	Depressive syndrome with worsening in the evening. - Emotional lability, - Irritability or even aggression - Sadness, - Difficulty falling asleep - Anxiety focused on the baby.
Severity	Minor dysfunction	Severe dysfunction (real psychiatric emergency requiring hospitalization).	Moderate to severe dysfunction.
Treatment	No medical treatment	Psychiatric emergency. Early antipsychotic treatment in a hospital setting.	Antidepressant medication (serotonin reuptake inhibitor) in mild forms. Hospitalization in severe forms.
Suicidal ideation	No suicidal ideation.	May be present Infanticide (+++).	May be present.

Main characteristics:

It is favored by maternal postpartum depression and therefore often appears with a time lag compared to maternal pathology. Episodes occurring later (1-2 months) are clinically less typical, have a poorer prognosis, and more frequently reveal a schizophrenic disorder.

The clinical picture includes [19,20]:

- Clouding of consciousness, mental confusion with temporal-spatial disorientation and dream-like state.
- Polymorphic delusional activity, mainly focused on pregnancy or the child.
- Fluctuation in mood.
- High risk of suicide or infanticide (+++).

Treatment:

This is a psychiatric emergency. Antipsychotic treatment should be initiated early in a specialized hospital setting [22].

3. CONCLUSION

Psychiatric disorders during pregnancy and the postpartum period require early detection and management. They can have harmful consequences on the mother's health and the child's development.

CONSENT

It is not applicable.

ETHICAL APPROVAL

It is not applicable.

COMPETING INTERESTS

Authors have declared that no competing interests exist.

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