ORIGINAL ARTICLE

Puerperal Psychosis – Analysis of 35 Cases

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Abstract

Thirty-five patients admitted with psychosis within six months of delivery were analysed for various risk factors. Primiparity, previous psychiatric history, antenatal complications, cesarean section, perinatal death and female baby were all associated with an increased risk of psychiatric admission, suggesting that psychological stresses do contribute to high psychiatric morbidity in puerperium. Women with history of affective disorder had a much higher risk of psychiatric admissions in the puerperium than those with history of schizophrenia or depressive neurosis.

Key Words

Puerperium, Psychosis, Affective disorders.

Introduction

The increased risk of psychotic breakdown in the puerperium is, well established. Women are more likely to be admitted to psychiatric hospital following delivery than at other times in their lives (1). In early stages of illness, the presentation is not typical. Most authors report nonspecific prodromal symptoms of lability of mood, lack of concentration, restlessness, insomnia, confusion, clouding of consciousness, irrational ideas and disorientation. The early presentation shows ready shifting from a picture typical of one mental illness to that of another or mixture of two. Identifying the women who are at risk for developing postnatal psychosis and instituting the treatment at an early stage helps in reducing the morbidity in such patients.

Material and methods

This retrospective study of two years was conducted in the Department of Psychiatry, Govt. Medical College, Jammu, and included thirty five patients admitted with psychiatric illness either immediately after childbirth or within 6 months of delivery. Detailed review of records was done with special reference to patient profile, past and family history, obstetrical history, current pregnancy complications, the diagnosis, and the response to treatment. Cases where the records were not clear or incomplete were excluded from the study. Cases were allocated to ICD-10 categories by the two persons independently.

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Results

The mean age of patients enrolled in our study sample was 26.4 ± 5.04 years. Eighty percent of patients were primiparae and 20% were multiparae. Past history of psychiatric disturbance was seen in 77.14% of patients, while 22.86% of patients had no positive past psychiatric history. More than 90% of patients had no previous family history of any psychiatric ailment. In 10 patients, it was the recurrent admissions following childbirth. 26 patients had no previous bad obstetrical history, while 8 had undergone previous spontaneous abortions. One patient had death of previous baby due to gastroenteritis. Antenatal complications in the form of antepartum haemorrhage, pre-eclampsia, anemia, intrauterine growth retardation were seen in 17 patients, 2 patients had prolonged labour, while 8 underwent cesarean section for various indications. 5 perinatal deaths were seen in study sample and there was a significant excess of birth of female babies (Table 1).

Table 1 : Risk factors in study cases

Risk Factors	Number	%age
Past history of psychiatric disturbances		
- Related to childbirth	17	48.57
- Unrelated to childbirth	10	28.57
- No past history	8	22.85
Family history of psychiatric disorder		
- Related to childbirth	2	5.71
- Unrelated to childbirth	1	2.85
- No family history	32	91.42
History of recurrent admissions following child birth	10	
Past obstetric history		
- History of spontaneous abortions	8	22.85
- No living child	1	2.85
- No bad obstetrical history	26	74.28
Current pregnancy		
- Normal vaginal delivery	10	28.57
- Some complication	25	71.43
- Antepartum complications	17	
- Prolonged labour	2	
- Perinatal death	5	
- Cesarean section	8	
- Female baby	23	

Nineteen patients were admitted after three months of delivery, 5 were brought within 14 days and 11 within 90 days of confinement. Twenty patients were discharged within two weeks of admission in satisfactory state, 2 had to stay for more than one month and 10 patients left the hospital against medical advice (Table 2).

Table 2 : Current admission features

	Number
Time of admission following delivery	
- Within 14 days	5
- Within 90 days	11
- After 90 days	19
Stay in hospital	
- Less than 14 days	20
- 20-29 days	3
- More than one month	2
Discharged against medical advice	10

Affective disorder constituted the major clinical group followed by non-organic psychosis and schizophrenic psychosis (Table 3).

Table 3 : Clinical diagnosis according to ICD-10

Clinical Diagnosis	Number	%age
Puerperal Neurosis	1	2.85
Affective Psychosis	23	65.71
- Major depression	18	
- Mania hypomania	4	
- Mixed attentive	1	
Schizophrenic psychosis	3	8.57
Paranoid state	2	5.71
Organic Psychosis	1	2.85
Non-organic psychosis	5	14.28

Discussion

It is well established that the incidence of psychiatric illness rises dramatically in the first few weeks or months after childbirth and that such illnesses are

more common in primipara and in those women with previous history of psychiatric illness (2).

Eighty percent of patients in our study series were primiparae and 20% were multiparae. As the birth of a child is often associated with some important changes in women's life, like loss of a job, social contacts, loss of freedom and changed marital relationship. Since such changes are much more likely to occur after the first delivery than the subsequent ones, so primiparity constitutes one of the important relative risk factors for puerperal psychosis. Previous history of psychiatric disturbance influenced the risk of psychiatric morbidity in puerperium in our study cases. Kendell also concluded that previous personal or family history of psychiatric illness increases the risk of puerperal psychosis and also that the occurrence of one puerperal psychosis increases the risk of a second episode from 1 in 500 to 1 in 7 or even less (2). Current pregnancy complications, cesarean section, perinatal deaths, female baby also form important relative risk factors for development of puerperal psychosis (1). Similar observations were noted in our study. Affective psychosis constituted the major clinical diagnostic group (65.71%) in our study. Dean and Kendell in their study of 81 Scottish women admitted with puerperal psychosis noted affective psychosis in 82% of cases (3). Many authors have reported that the past history of an affective disorder caries a higher risk of puerperal breakdown than at other times, while women with schizophrenic disorders have more or less equal risk of relapse following childbirth as at other times. Platz and Kendel have also suggested that childbirth is capable of precipitating episodes of illness in women with only or moderate genetic or constitutional predisposition to affective disorder (4).

Due to various social taboos existing in our society, only the severe cases are brought to the hospital and an unknown number of women suffering from puerperal illness are treated by local healers or receive no treatment at all. Cox in his study of postnatal illness among African women reported that these patients were more likely to seek help from a traditional healer than to visit a doctor (5). The results of our study also supported the fact that the patients were brought for admission only once the spontaneous recovery was delayed or when traditional healers proved unsuccessful, as 54.28% of our patients got admitted after 3 months of delivery.

To conclude, our results were in broad conformity with other authors but need to be supplemented with more controlled studies in future in order to have a definitive inference regarding various risk factors involved in patients of puerperal psychosis.

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