Minireview Article

The Baby Blues and Perinatal Psychic Disorders: About Prevention and Management

Abstract:

The baby blues is a precocious psychic impairment that may occur within the first two weeks following delivery. It is considered as a trigger point, and sometimes a decompensation towards more serious postpartum psychiatric disorders. It is as well a hazard, predisposing to abnormal psycho-affective development in infants, otherwise intimately dependent on maternal bonding. Although there have been advances in understanding the psychopathology, the clinical presentations and the inter-relationship of the condition with other disorders of perinatality, the management however remains unclear and poorly described. There seems to be confusion between indications for mere observation with monitoring on one hand, and the need for psychotherapy or pharmacotherapy on the other hand. This is maintained by the ambiguous distinction between primary baby blues which is milder, and the severe baby blues with immediate and late complications that are sometimes neglected. Whereas, intervention may be necessary in a number of cases to prevent adverse outcomes in affected mothers and their infants. In this short paper we review the management of the baby blues according to severity and we give clues for prevention, based on known protective factors.

Key words: Baby blues, Perinatality, postpartum depression, psychosis

Introduction:

The effective prevention and management of the baby blues should take place and span throughout the duration of the pregnancy and beyond the immediate postpartum period. In effect, adverse events that are likely to impact the course of the pregnancy, the delivery process and maternity in postpartum may occur very early after conception, and so should be avoided as much as possible to ease perinatality [1-6]. This process is known as the “carry over phenomenon” and needs to be prevented through a number of measures. More than 80% of cases with baby blues may be described as primary blues with mild transient or benign presentation. This form of postpartum blues is closer to a normal physiological process than to a psychiatric disorder. However, 20% with more severe signs and symptoms may be real mental impairments, presenting as a “signal” or “trigger point” towards more serious psychiatric disorders of postpartum, and with related complications [1-6].

As a general rule, the primary baby blues to the sense of Kennerley and Gath is of precocious onset and fleeting, requiring only mothers specific counselling, assistance, monitoring and support from entourage. It is such a mild condition that it may be unnoticed to the medical staff [1-6]. Whereas, the severe blues with atypically serious symptomatology and lasting for more than ten days necessitates psychiatric assessment, psychotherapy and/or medication for treatment. This is because of the fact that the severe baby blues is very likely to progress towards delivery-bound post-traumatic stress disorder, postpartum depression, or psychosis [1-6].

Documented protective factors against the onset of the baby blues include women having from average to high socioeconomic situation, a peaceful family, good and satisfying couple relationship, benefiting adequate financial support from the partner, family or friends, adequate emotional support from the partner, family or friends, being able to rely on the partner, family or friends when need be, having confidence in the partner and friends, having planned the pregnancy, desired and done prenatal check-up. These factors are thought to procure a strong psychosocial support network which is reassuring and psycho-prophylactic for mothers during the perinatal period [1-6].

As a matter of fact, besides the biological theory with hormonal imbalances of pregnancy justifying the blues, the psychodynamic theory of mental representations and maternal infantile conflicts have a central role in the psychogenesis. Given the reluctance of physician to intervene on physiological endocrinologic changes of perinatility, and for presumed mild affections such as the blues, the management relies mainly on the reinforcement of psychosocial support and/or psychotherapy. Moreover, the effective management of concomitant maternal or neonatal health issues including infections, injuries and pains, that are likely to induce, maintain or worsen the blues through summation effect, is important as well [5-12].

Prevention and Management

During pregnancy, antenatal visits should be observed by women with targeted counselling and information about the progress of pregnancy, the development of the foetus, preparation to delivery and maternity [12-22]. This contributes to reassure the mother and her partner, preventing worries and anxiety. It also helps to anticipate on problems and challenges, so as to better manage them and avoid last minute surprises [22-30]. In effect, in case a congenital birth defect or malformation is early diagnosed, parents' assistance with a psychologist is indispensable and should absolutely be recommended by the physician. This will facilitate gradual acceptation of the diagnosis, with understanding of the embryo-fetopathy, conditioning and coping, motivation to continue visits and treatment observance [15-33].

In the course of the delivery process, trauma should be avoided as much as possible and labour facilitated through optimal obstetrical practices. Dystocic deliveries should be made less traumatic as possible with analgesia and effective anaesthesia when caesarean section is indicated. The presence of the husband or partner should be allowed in the delivery room and/or operating theatre when possible, for sympathetic assistance and mothers reassurance. Optimal obstetrical practices, just as safe delivery and effective analgesia have the double advantage of preventing pain-induced depression and enables the mother to take care of the neonate immediately, following delivery [6-22].

After childbirth, postpartum blues management requires mothers support with counselling and education on the benign and transient character of their physical and mental discomforts [1-6]. They should be reassured of the restoration of their body organs including uterine involution, cessation of lochia, wound healing and weight loss, just to name some. This is cheering and recomforting for mothers and helps to break anxiety too. Furthermore, the medical staff should emphasise to mothers' entourage and relatives, her needs for enough rest and emotional support, assistance with baby care, balanced feeding with enough hydration, breastfeeding practice and techniques [7-14]. Through such measures, mothers are relieved from a number of unnecessary preoccupations, so as to appease their minds and strengthen confidence, while enhancing optimism.

Mother's responsibilities as well as the necessity for good interactions with the baby are discussed with the medical staff. This helps mothers to understand the importance of the mechanisms of bonding establishment, and its "psycho-prophylactic" effects for both mother and infant, on the short and long term. Analgesia should be maintained or increased if necessary, and mothers should be thought or assisted with perineal care [7-22].

All these interventions may be complementary to cognitive and behavioural therapy, aimed at improving patients' thoughts and behaviours for a more comfortable psychological adaptation to the postpartum period. Family and relatives' support through sympathising and reassurance helps to calm down the mother, thereby favouring contending, with the additional benefit of not administering drugs [1-6].

After mother's discharge from hospital, positive interactions with loved ones should be maintained. In particular cultures such as in Africa, newly delivered women are fed with dishes that contain natural uterotonics and lactogenic galactogogues which are respectively responsible for uterine involution and increased breastmilk production [7-22]. Postnatal visits should be regularly observed with reassessment and close follow-

up of women with severe maternity blues to prevent postpartum depression. Nurse visit to newly delivered mothers' home may serve a great purpose as well, when proximity healthcare practices are possible. However, newly delivered women are often given the following recommendations before their discharge:

- To avoid extreme fatigue. Sleeping when the baby is sleeping. Allowing their partners or other support person to take care of the baby occasionally, so they can get extra rest
- Concentrate on themselves and the baby, letting others help with housework, laundry, cooking, shopping and other stressful activities
- Get out of the house every day or when possible
- Go for a walk and/or meet a friend
- To treat themselves to something they like to do
- Share their feelings and frustrations with their partners or a close friend.

They are also advised to notify their health care provider in case feelings of sadness, anxiety, resentment or guilt last longer than 2 weeks and interfere with their ability to care for themselves and/or the baby [34-44].

Given that severe maternity blues can easily progress towards post-partum depression and other psychic disorders of perinatality if poorly managed, newly delivered women are advised to keep in contact with their health care providers. They are also encouraged to contact their physician in case they experience any of the following symptoms of depression and anxiety disorders:

- Inability to sleep or sleeping all the time
- Loss of appetite
- Feeling down most of the time
- Feeling even the smallest task seem to take too much effort
- Feeling very critical of themselves or others
- Worrying constantly about the baby
- Having thoughts of harming themselves or the baby.

While psychotic manifestations will be reported by family members and partners if present. In such cases with baby blues complications, mental reassessment should be done by the medical psychologist or the psychiatrist, and the need for intense psychotherapy or drug prescription appreciated.

The administration of progesterone in postpartum to prevent severe baby blues mental impairments is often recommended by most clinicians to quench progression

towards postpartum depression. This therapeutic intervention is based on the endocrinological theory of baby blues onset, with estimated progesterone drop after delivery [34-44]. Following psychiatric reassessment, complications with postpartum depression which are the most frequent will be managed through sessions of psychotherapy as outpatients and the prescription of anti-depressants. Such medications mainly include serotonine recapture inhibitors and mood or thymoregulators. In addition to this, treatment for any other medical issues related with depression will be administered as well. Although these mothers could be allowed to continue caring for their babies with breastfeeding, the drugs are known to be secreted in breastmilk, but in low doses that are harmless to the baby [7-14]. The treatment of postpartum depression may last up to six months so as to prevent chronic depression. Contrarily to postpartum depression, post traumatic stress related with delivery is best managed through cognitive behavioural therapy consisting of debriefing, counselling and positive interactions during few weeks or months [34-44]. Generally, no medication is required. Bad habits such as doping, illicit psychotropic drug consumption including alcohol are prohibited, as they may worsen the condition.

In case of postpartum psychosis, mothers should be separated from infants according to the severity of their condition. They may be hospitalised with physical or pharmacological contention in case of acute delirium with agitation or aggressiveness. Antipsychotic drugs are required in combination with mood stabilizers or thymoregulators and benzodiazepines to control signs and symptoms [34-44]. Breastfeeding is not possible because of mother-infant separation with decreased breastmilk secretion, and also due to antipsychotic drugs which are harmful for the baby. In the meantime, the baby can be fed with human donor milk or formula milk. The infant may be adopted and cared for by a family member, with the advantage of being safe from nosocomial infections, or it may be kept in the hospital's maternity and close to the mother, but with risk of hospital borne-infection.

Conclusion

The psychic disorders of perinatality and postpartum are quite common, starting with the baby blues. When diagnosed, they should be further assessed by the mental health specialist for clinical distinction and precision. Most cases with primary blues and post traumatic stress may uniquely be managed by cognitive behavioural therapy. While more serious conditions such as postpartum depression and psychosis respectively require antidepressants and antipsychotics in addition. Although the management of the later conditions may last for months, mother-infant bonding should be preserved as much as possible to prevent complications with baby psycho-affective development.

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