CHAPTER 1

Historical perspectives and classification issues

French pioneers and current opinion

Louis Victor Marcé, a brilliant pupil of Jean-Étienne Dominique Esquirol in Paris, in his seminal thesis in 1858, regarded the temporal association between postnatal illness and childbirth as its defining characteristic (Marcé, 1858). He also anticipated the development of endocrinology by delineating a 'morbid sympathie' between the postnatal mental state and bodily functions. A further observation by this scholarly 'ancien intern' was to identify certain symptoms of childbearing-related mental disorder that were rarely found together in non-puerperal mental disorders. Marcé recognised the specific forensic aspects of these case histories and, in particular, the risk to the infant and the mother of a severe puerperal psychosis. He may himself have suffered from bipolar disorder – and it is suggested by Luauté *et al* (2012) that he died by suicide. His pioneering work in his short life was honoured by the founders of the Marcé Society, which was named after him.

In this way, Marcé – and Esquirol, who in 1838 reported on a large study of postnatal illness in Paris – set the stage for further work in this field. It is regrettable that their work was largely lost to European psychiatry until the 1970s when the Marcé Society was founded.

Until the mid-20th century, puerperal psychosis continued to be regarded as a distinct condition. Numerous papers, comprehensively reviewed by Brockington (1996), were published; these described in detail the psychopathology of women with 'lactational psychosis', who experienced delusions about the baby and sexual infidelity, as well as religious themes. Confusion and perplexity were observed in many such women with non-infective psychoses, and such illnesses often resulted in the death of the mother and severe neglect of the baby. Menzies (1893) provided an account of many such women who were admitted to Rainhill asylum in Lancashire, and he made the customary distinction between lactational and other psychoses.

In the Middle Ages, madness after childbirth was more likely to be regarded as a religious than a medical problem. The mother was a 'witch' and her 'possession' was a punishment for misdemeanour. A postpartum mother was considered to be unclean, and a 'churching' cleansing ritual was therefore necessary to purify her. This ceremony was also attended by the midwife, and only after the churching had taken place could the mother again enter the church or attend Mass. In her autobiography, Margery Kempe (born 1373), who was a mediaeval mystic, described her recurrent postpartum mental disorders – which did not impair her ability to travel widely (Kempe, 1985).

In pre-Christian times, Greek physicians from the school of Hippocrates on the island of Kos were more holistic in their approach to mental disorder. Although they regarded mental disorders, including postnatal mental disorder, as having biological causes (milk diverted from the breast to the brain, or suppression of lochial discharge), prayers were also offered to gods such as Aesculapius or Apollo as part of the healing process.

It is apparent from this glimpse of medical history that postpartum mental disorders were thought to be different from those occurring at other times – and that the provision of healthcare varied according to the prevailing beliefs about causation. The choice of therapy was determined by the local culturally endorsed explanatory model. Deference to the now dominant scientific biomedical model for the causes of perinatal mental disorder might partially explain, for example, the still-popular beliefs that hormones are causal (e.g. Dalton, 1980) or, more recently, that receptor sensitivity (Wieck *et al*, 1991) or genetic vulnerability are the sole determinants.

International classifications

International classifications of mental disorders – ICD-10 (World Health Organization, 1992) and DSM-V (American Psychiatric Association, 2013) – likewise reflect the dominant values of society, as well as the search for a common diagnostic language for clinicians and researchers across the world. Interestingly, the recently published DSM-V has re-emphasised the place of clinical judgement in psychiatric assessment, and the limitations of categorical operational approaches have been discussed (Maj, 2013). This more holistic integrative approach to diagnostic assessment is helpful and could facilitate increased understanding of the complex sociocultural context of perinatal mental disorder, and of the mother–baby relationship.

Despite the plethora of papers describing puerperal psychoses published in the late 19th and early 20th centuries, this diagnosis was nevertheless completely removed from ICD-9. Women with a postnatal onset of severe mental disorder were not thought to have any characteristics not found in mental disorders at other times – a consideration that remarkably overlooked the relevance of the development of the mother–infant relationship. This

omission was partially corrected in ICD-10, when a 6-week postpartum onset specifier was introduced, and in DSM-IV (APA, 1994) by the addition of a 4-week specifier – but only for affective disorders. In ICD-10, the category of puerperal psychosis was to be used when the perinatal mental disorder could not be classified elsewhere, as might occur in a low-resource country. This limitation of ICD-10 for public health records, and for use by commissioners and providers of healthcare who wish to audit or cost a perinatal mental health service, was glaringly apparent. Currently, it is not possible to identify routinely from hospital records women at risk of a psychosis after childbirth, nor those who develop a mental disorder during pregnancy or the puerperium. A public enquiry following the deaths of the psychiatrist Daksha Emson and her baby, for example, recommended not only the establishment of specialist perinatal psychiatry services but also improved screening for women at high risk of puerperal psychosis (North East London Strategic Health Authority, 2003). These services will be greatly facilitated by a more inclusive ICD-11, which recognises the distinctive diagnoses of mental disorders that occur during pregnancy or following childbirth.

Towards ICD-11 and DSM-V

The World Health Organization and the World Psychiatric Association have undertaken a radical critique of the existing international classifications, which is well summarised in a comprehensive and readable book edited by Salloum and Mezzich (2009). The authors recommend in their concluding chapter that psychiatric diagnosis should become more integrative. A comprehensive person-centred integrative diagnosis would include measures of positive health as well as illness, and consider quality of life and relationship problems which trigger mental disorder, as well as protective factors. Any new classification should make sense to patients as well as clinicians. International classifications should be a spur to creative thinking and should not restrict innovation (Cox, 2002). If a scientific evidence base for a classification is accepted uncritically, and values are ignored or the meaning of the illness for the patient is overlooked, then the classification can produce the 'mind-forg'd manacles' decried by William Blake rather than being a system of conceptual thought which provides a vehicle of communication for clinicians, researchers and patients. When J.C. worked in Uganda in the early 1970s, ICD-8 was being revised, and the exclusion of puerperal psychosis was in stark contrast to the experience of local psychiatrists – and contrary to the Kiganda classification of mental disorder, which included amakiro, a traditional puerperal illness (Orley, 1970).

It was recommended by the Royal College of Psychiatrists Perinatal Section Nosology Working Group that ICD-11 should include a new separate antenatal and postnatal onset specifier of 3 months for each ICD category of mood disorder, as well as for schizoaffective disorder and acute

Box 1.1 ICD-10 F53 Mental and behavioural disorders associated with the puerperium

This category is unusual and apparently paradoxical in carrying a recommendation that it should be used only when unavoidable. Its inclusion is a recognition of the very real practical problems in many developing countries that make the gathering of details about many cases of puerperal illness virtually impossible. However, even in the absence of sufficient information to allow a diagnosis of some variety of affective disorder (or, more rarely, schizophrenia), there will usually be enough known to allow diagnosis of a mild (F53.0) or severe (F53.1) disorder; this sub division is useful for estimations of workload, and when decisions are to be made about provision of services.

The inclusion of this category should not be taken to imply that, given adequate information, a significant proportion of cases of postpartum mental illness cannot be classified in other categories. Most experts in this field are of the opinion that a clinical picture of puerperal psychosis is so rarely (if ever) reliably distinguishable from affective disorder or schizophrenia that a special category is not justified. Any psychiatrist who is of the minority opinion that special postpartum psychoses do indeed exist may use this category, but should be aware of its real purpose.

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and transient psychotic disorder. Austin (2010) has proposed that a code for mother–infant interaction difficulties should also be introduced into ICD-11 to encourage clinicians to consider the impact of maternal illness on the infant and to assist policy makers in this field. Brockington *et al* (2009) have similarly suggested that a category of disorder of mother–fetus and mother–infant relationship is considered for ICD-11, as difficulties in these relationships represent a high risk for child abuse and neglect. We suggest that ICD-11 should be inclusive of popular culturally conditioned categories such as puerperal psychosis and postnatal and antenatal depression, which – although lacking agreed diagnostic specificity – are nevertheless useful for patients and policy makers.

Postmodern societies in transit

Any classification should be valid as well as reliable, and it should also be meaningful and understood by patients and their families. The World Psychiatric Association's International Guidelines for Diagnostic Assessment (Mezzich *et al*, 2002) innovatively included a narrative and descriptive approach to patient assessment and proposed that quality of life and the patient's belief system, including their religious beliefs, should be routinely considered.

The ICD-10 classification of mental and behavioural disorders concluded its preface with the apposite reflection that 'a classification is a way of seeing

Box 1.2 ICD-10 F53 Mental and behavioural disorders associated with the puerperium, not elsewhere classified

F53.0 Mild mental and behavioural disorders associated with the puerperium, not elsewhere classified

Includes: postnatal depression NOS

postpartum depression NOS

F53.1 Severe mental and behavioural disorders associated with the puerperium, not elsewhere classified

Includes: puerperal psychosis NOS

F53.8 Other mental and behavioural disorders associated with the puerperium, not elsewhere classified

F53.9 Puerperal mental disorder, unspecified

This classification should be used only for mental disorders associated with the puerperium (commencing within 6 weeks of delivery) that do not meet the criteria for disorders classified elsewhere in this book, either because insufficient information is available, or because it is considered that special additional clinical features are present which make classification elsewhere inappropriate. It will usually be possible to classify mental disorders associated with the puerperium by using two other codes: the first is from elsewhere in Chapter V(F) and indicates the specific type of mental disorder (usually affective (F30–F39), and the second is 099.3 (mental diseases and diseases of the nervous system complicating the puerperium) of ICD-I0.

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the world at a point in time'. In recent decades, this world has become globalised with increased migration, so that the classification of mental disorders in general, and perinatal mental disorders in particular, now need to be carefully reviewed (Box 1.1 and 1.2).

Although there was no specific category for puerperal psychosis in DSM-IV, some of the distinctive features of perinatal mental disorders were nevertheless usefully listed in the accompanying text (Box 1.3). The addition of the peripartum onset specifier in DSM-V is to be applied to the current or most recent depressive, manic or hypomanic episode in major depressive disorder, bipolar I or bipolar II disorder if the episode occurs during pregnancy or in the 4 weeks following delivery. This broadening of the scope of the specifier is welcome – but, as noted by Sharma & Mazmanian (2014), it is unfortunate that no distinction is made between prepartum and postpartum onset of mental disorder. Later editions of DSM-V should also reconsider the time period after childbirth when the specifier is applicable. We would suggest that it is extended to 6 months, a time interval that is consistent with the present evidence base.

Box 1.3 DSM-V peripartum onset specifier

With peripartum onset:

This specifier can be applied to the current or, if full criteria are not currently met for a major depressive episode, most recent episode of major depression if onset of mood symptoms occurs during pregnancy or in the 4 weeks following delivery.

Note: Mood episodes can have their onset either during pregnancy or postpartum.

Although the estimates differ according to the period of follow-up after delivery, between 3% and 6% of women will experience the onset of a major depressive episode during pregnancy or in the weeks or months following delivery. Fifty percent of 'postpartum' major depressive episodes actually begin prior to delivery. Thus, these episodes are referred to collectively as peripartum episodes. Women with peripartum major depressive episodes often have severe anxiety and even panic attacks. Prospect ive studies have demonstrated that mood and anxiety symptoms during pregnancy, as well as the 'baby blues,' increase the risk for a postpartum major depressive episode.

Peripartum-onset mood episodes can present either with or without psychotic features. Infanticide is most often associated with postpartum psychotic episodes that are characterized by command hallucinations to kill the infant or delusions that the infant is possessed, but psychotic symptoms can also occur in severe postpartum mood episodes without such specific delusions or hallucinations. Postpartum mood (major depressive or manic) episodes with psychotic features appear to occur in from 1 in 500 to 1 in 1,000 deliveries and may be more common in primiparous women. The risk of postpartum episodes with psychotic features is particularly increased for women with prior postpartum mood episodes but is also elevated for those with a prior history of a depressive or bipolar disorder (especially bipolar I disorder) and those with a family history of bipolar disorders.

Once a woman has had a postpartum episode with psychotic features, the risk of recurrence with each subsequent delivery is between 30% and 50%. Postpartum episodes must be differentiated from delirium occurring in the postpartum period, which is distinguished by a fluctuating level of awareness or attention. The postpartum period is unique with respect to the degree of neuroendocrine alterations and psychosocial adjustments, the potential impact of breast-feeding on treatment planning, and the long-term implications of a history of postpartum mood disorder on subsequent family planning.

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What is special about perinatal mental disorders?

This question was considered at an international workshop in Sweden held in 1996, when the following characteristics of perinatal mental disorder were agreed:

- the birth context, which shapes experience and expression of the perinatal disorder

- the impact on the mother, which has the potential to damage self-image at a time of transition
- the impact on the child, partner and family, during a particularly sensitive period
- the high morbidity of untreated perinatal mental disorder, which has a cascading adverse effect on the family
- an increased readiness to provide assistance in the postnatal period
- better availability of systems to help, because community health services are organised to ensure frequent contact
- lower stigma in some countries because of high-profile public figures and successful advocacy groups
- high yield for intervention because of the preceding circumstances
- birth as a potential trigger
- distinctive biological components, relating to pregnancy and birth
- onset contrary to a cultural expectation of happiness.

Problems with the current classifications of perinatal mental disorder include:

- failure to include an obligatory antenatal and postnatal onset specifier
- failure to use a research-supported time period for onset after delivery; evidence from case-register studies indicates that the majority of excess presentations over expected rates occur within 3 months of delivery (Kendell *et al*, 1983; Munk-Olsen *et al*, 2006)

In addition, DSM-V does not allow easy coding for an acute mixed atypical psychosis, which is commonly seen by clinicians who treat severe postpartum disorders.

Non-psychotic unipolar postnatal depression

Current diagnostic systems do not deal well with the milder (subsyndromal or subthreshold) depressions, which are increasingly recognised as being widely prevalent and of high associated morbidity. These are of particular importance in the postnatal period because of the risks they present to optimal child development and the frequency with which they develop into major depression. It is helpful to consider the perinatal mental disorders on a continuum from mild to severe; premonitory mild anxiety and depression can be a precursor of puerperal psychosis, bipolar disorder and a major depressive disorder. The popular term postnatal depression may be used as a category for a group of mood disorders that are exacerbated or triggered by childbirth. These are mostly unipolar disorders and can be subthreshold, or subsyndromal, because they are not usually characterised by delusions or obvious behavioural disturbances. Postnatal depression is a term commonly used by public health departments, by many advocacy groups and by the women themselves and should therefore be retained in ICD-11.

Summary

This chapter has discussed the ways in which the classifications of perinatal mental disorder are partly derived from cultural assumptions and values, as well as from the findings of biomedical research. The debate about the optimal classification of perinatal mental disorder has illustrated that the birth event and its associated mental disorders can be fully understood only if there is a grasp of the individual within a cultural context, and that explanatory models which span the brain and the mind, and the mother and her infant, and which include existential dimensions, should be more actively considered.

It is our opinion, based on research and clinical work in this field, that it is in the best interest of these disturbed mothers with their need for skilled specialist help to include a mandatory prepartum and postpartum specifier in the revised classifications for all perinatal mental disorders. Furthermore, the diagnostic category of puerperal psychosis, because of its specific social context, its characteristic delusional content and its specific management, should be retained.

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