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Letter to the Editor

Psychiatric risk factors in peripartum: the need for targeted approaches

Dear Editor,

The issue of mental health care in peripartum patients has been gaining considerable attention among clinicians, given its potential to affect pregnancy outcomes for mothers and children as well as the developmental pathways of infants in their first months of life. It is essential to stress the medicolegal implications that might arise from an inadequate psychological/psychiatric patient assessment, from the standpoint of being able to evaluate such risk factors and put in place prompt targeted interventions. The peripartum period in fact encompasses pregnancy until the first year postpartum and is deemed to be a considerable vulnerable time for patients with mental illnesses, both incident and recurrent ones. Moreover, the risk of developing psychiatric conditions is considerably higher during postpartum[1].

Research findings have shown how the risk of suffering from mental illness is the highest for women in their reproductive years. The risk is even higher as childbirth sets in. Among the most consequential contributing factors, it is worth mentioning neurohormonal changes in pregnancy and childbirth, the challenges arising from the need to adapt from a psychological standpoint, and the social challenges thereof. A significant number of maternal deaths in pregnancy and in the first year after childbirth has been reportedly linked to psychiatric disorders, and maternal mental illness can result in extremely severe consequences. Studies[2,3] have pointed out how suicide is among the leading causes of maternal death, highlighting how the harmful effect of untreated maternal psychiatric conditions such as depression and anxiety can impact neonatal development. Patients may take psychotropic drugs at conception and in pregnancy, and antidepressants are among those most often prescribed. Nonetheless, psychotropics may result in major adverse effects on fetal and neonatal development: it is therefore incumbent upon the doctors to make a thorough assessment aimed at identifying patients at risk. On the other hand, the discontinuation of psychiatric therapeutic drugs is known to substantially raise the risk of relapse. Finding a balance between those different needs can be essential in order to reduce morbidity and mortality and allay the harmful effects of prescription medication.

Active peripartum psychiatric illness reportedly entails a higher risk of adverse outcomes in intrapartum for exposed pregnancies/children. Likely due to high rates of obesity, pregnant women with psychiatric illness also have higher rates of preeclampsia, cesarean section, and gestational diabetes, which can make severe pregnancy complications more likely[4-6]. Children themselves are likely to be affected: postpartum depression has in fact been linked to lower intelligence quotient (IQ), language delays, and behavioral problems in exposed children. In addition, perinatal maternal depression has been linked to altered emotional regulation and attachment issues[7]. This can be explained by looking at factors, such as fluctuations in hormonal levels, hypothalamic-pituitary-adrenal axis reactivity, genotypes, neurosteroids, neurotransmitters, inflammatory cytokines among others. Influences on the degree of vulnerability to perinatal psychiatric symptoms have also been reported, among which stressors and social role transitions. Studies of epigenetic influences on fetal development have elucidated the correlation between maternal antenatal depression, a higher risk of preterm birth and heightened stress sensitivity in offspring. A growing body of evidence along with more effective metho-

Corresponding Author: Gabriele Napoletano, MD; e-mail: gabriele_napoletano@protonmail.com

dology have substantially clarified the risks of psychotropic medications during pregnancy[8]. In addition, inadequate levels of detection and treatment of perinatal psychiatric issues are starting to improve, thanks to new approaches aimed at integrating mental health care into perinatal care settings[9] by fostering intrapartum practices and techniques that prioritize the patient's special needs while tailoring a set of interventions suitable to meet them. Moreover, it is of utmost importance to outline and pursue a multidisciplinary approach when providing care to patients with mental vulnerabilities who are also at risk for gynecological complications[10]. Patients suffering from schizophrenia, for instance, risk incurring complications during the perinatal period at a much higher rate than in the general population. Moreover, a higher likelihood of operative deliveries has been reported in such patients, with all the risks thereof, and of neonatal morbidity and neonatal intensive care admission[11]. Adherence to guidelines and recommendations at this stage is very important to reduce the likelihood of adverse outcomes and stave off malpractice litigation[12,13] arising from negligence and non-compliance with best practices[14-16]. Intrapartum management of women with mental disorders requires obstetricians to face several clinical challenges which are further exacerbated when such patients are admitted already in labor, with decision making constrained due to the circumstances. At the same time, overly invasive obstetrical techniques should not be performed, or at least kept to a minimum, given the risks related to the patient's mental vulnerabilities[17]. It is therefore of utmost importance to be able to rely on thorough, standardized and evidence-based criteria for the psychiatric assessment of the peripartum patient, a cornerstone of which is the standard psychiatric interview designed to lay the groundwork for a sound therapeutic alliance. In that regard, it is essential for clinical specialists to assess concerns and feelings relative to pregnancy, delivery, feeding, fertility, conception, and available social supports, taking into account obstetrical/gynecologic history, and keep in check possible psychiatric symptoms liable to entail higher risk. Those should include, but not be limited to, postpartum manic and psychotic symptoms, thoughts of infanticide and/or suicidal ideation. The dynamics unfolding within the couple should also be weighed and taken into account, for the purpose of providing support to the patient's partner as well, based on gender-tailored approaches that prioritize the mental well-being of both prospective parents. There is in fact no denying that striving for a tenable balance within the couple can be a major determining factor in tackling unhealthy psychiatric manifestations and in fostering an overall climate conducive to mental health preservation for patients at risk[18]. Only through a comprehensive clinical interview an accurate psychiatric diagnosis can be produced in a timely fashion. Successful symptom resolution and remission can only be achieved through the collaboration between patients and obstetricians/gynecologists and mental health specialists.

Psychiatric symptoms are among the most prevalent perinatal complications. The withdrawal or underdosing of psychotropic drugs in pregnancy may bring about symptom recurrence. Documenting the various stages through which the decision-making process unfolded is also non-negotiable. Objective standards therefore need to be laid out, providing a beacon light for clinicians towards the implementation of medically, ethically and legally sound interventions for the sake of patients in a state of vulnerability due to their mental conditions. Failing to meet such standards would amount to an intolerable violation of the reproductive rights and procreative autonomy of psychiatric patients.

Conflict of Interest

The Authors declare that they have no conflict of interests.

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S. Napoletano[1], G. Di Caro[2], G. Napoletano[3]

[1]UO Medicina Legale Ausl Piacenza, Piacenza, Italy
[2]AOOR Villa Sofia Cervello, Department of Obstetrics and Gynecology, University of Palermo, Palermo, Italy
[3]Department of Anatomical, Histological, Forensic and Orthopedic Sciences, "Sapienza", University of Rome, Rome, Italy