



AN OBSERVATIONAL RESEARCH ON DISABILITIES OF PREGNANCY: A CASE STUDY AT SHIMLA, HIMACHAL PRADESH

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Abstract-For a woman, pregnancy is usually assumed to be a period of relaxation and mental well-being. Pregnancy and motherhood, however, increase their susceptibility to medical problems such as depression, anxiety disorders, eating disorders, and psychosis for many women. These disorders are often underdiagnosed because they are due to modifications in maternal temperament or physiology linked to pregnancy. Furthermore, because of concerns about the adverse effects of treatment, such disorders are frequently undertreated. Practitioners and associated health practitioners who look after pregnant or postpartum patients. This article delineates to explain the different types of Disorders in Pregnancy in Himachal Pradesh. It also tells to characterize the most common peripheral and central neurological disorders during pregnancy in Himachal Pradesh.

Keywords: Pregnancy, Anxiety Disorders, Eating Disorders, Disorders, Central Neurological

1. Introduction

During pregnancy, it is often difficult to differentiate signs of depression, such as changes in sleep, appetite, and energy, from typical pregnancy experiences. While up to 70% of women report some negative mood symptoms during pregnancy, it has been shown that the prevalence of women meeting the diagnostic criteria for depression varies from 13.6% at 32 weeks gestation to 17% at 35 to 36 weeks gestation. The course of depression varies during pregnancy: during the first and third trimesters, most studies show a peak of symptoms and improvement during the second trimester. More women were depressed between 18 and 32 weeks of gestation than between 32 weeks of gestation and 8 weeks postpartum in a recent study. The most common medical condition associated with pregnancy is depression. Anxiety disorders, such as panic disorder, obsessive-compulsive disorder, and eating disorders, can also occur in pregnant



women. While it is unusual for women to experience first-onset psychosis during pregnancy, for women previously diagnosed with any type of psychosis, relapse rates are large. (The full review of pharmacological and non-pharmacological therapies for these disorders will be published in April 2005 in Part 2 of this topic.)

During pregnancy, multiple risk factors and psychosocial associations have been reported as leading to depression. A prior history of depression, discontinuation of medication(s) by a woman who has a history of depression, a previous history of postpartum depression, and a family history of depression are the most specifically defined risk factors. Depression during pregnancy can also be triggered by many main psychosocial correlations: a negative attitude towards pregnancy, a lack of social support, maternal stress associated with negative life events, and a partner or family member who is dissatisfied with pregnancy.

2. Psychiatric Disorders During Pregnancy

Even though pregnancy has typically been viewed as a time of emotional prosperity, recent studies propose that up to 20% of women suffer from mood or anxiety disorders during pregnancy. Especially defenseless are those women with chronicles of psychiatric illness who stop psychotropic drugs during pregnancy.

In a recent report which tentatively followed a gathering of women with narratives of significant depression across pregnancy, of the 82 women who maintained antidepressant treatment all through pregnancy, 21 (26%) relapsed contrasted and 44 (68%) of the 65 women who discontinued medicine. This research assessed that women who discontinued medicine were five times as liable to backslide when contrasted with women who maintained treatment in Himachal Pradesh.

High rates of backsliding have additionally been observed in women with bipolar disorder. One examination demonstrated that during pregnancy, 70.8% of the women experienced, in any event, one mood scene. The risk of repeat was fundamentally higher in women who discontinued treatment with mood stabilizers (85.5%) than the individuals who maintained treatment (37.0%).



3. Major Depression in Pregnancy

Major depression is twice as common in women as in men and frequently clusters during the childbearing years. Although pregnancy has traditionally been considered a time of emotional well-being for women conferring protection against psychiatric disorders, at least one prospective study describes rates of major and minor depression as approximating 10%. Women with recurrent major depression who have been maintained on an antidepressant medication before conception appear to be at unusually high risk for relapse during pregnancy [13].

There have been cumulative data to support the relative safety of using certain antidepressants during pregnancy in Himachal Pradesh. High rates of relapse occur after discontinuation of maintenance pharmacological treatment in non-gravid populations. In women who have been diagnosed as recurrent depression before conception and in whom antidepressant medications have been discontinued, rates of relapse can approximate 75%. They can be seen frequently during the first trimester[14].

Commonly, depression during pregnancy can be missed. Pregnant women may have many clinical signs and symptoms overlapping with those seen in major depression (e.g., sleep and appetite disturbance, diminished libido, and low energy). Some medical disorders commonly seen during pregnancy, such as anemia, gestational diabetes, and thyroid dysfunction, may be associated with depressive symptoms and may complicate the diagnosis of depression during pregnancy.

4. Treatment Of Specific Psychiatric Disorders

Psychotherapies: Interpersonal therapy (IPT) addresses four major problem domains concerning human psychosocial functioning – grief, interpersonal disputes, role transitions, and interpersonal deficits[15]. Keeping in mind the importance of interpersonal relationships in couples expecting a child, and the significant role of changes that take place during pregnancy and after delivery, IPT is ideal for the treatment of the depressed pregnant women.



A more recent controlled clinical trial of IPT versus parenting education program found that the interpersonal psychotherapy treatment group showed significant improvement compared to the parenting education control program on measures of mood at termination, thereby concluding that IPT is an effective method of antidepressant treatment during pregnancy. Cognitive behavior therapy (CBT) has also been reported to be beneficial.

St-Andre selected four psychotherapy themes during brief conflict focused interventions with pregnant women and their families. The first theme was conflict over increased dependency needs, second was narcissistic disturbances and pregnancy, third was reconciliation themes in pregnancy, and fourth was, working through losses while giving life. The emphasis was on the developmental receptivity of pregnant women to psychotherapeutic interventions.

Antidepressant treatment: Antidepressants during pregnancy are indicated for women whose symptoms interfere with maternal well-being and functioning. Medication choice is based on prior treatment response. During pregnancy, fluoxetine is usually the first line antidepressant choice, based on its having the most existent literature supporting its reproductive safety. Other first-line choices include TCAS, particularly nortriptylines and desipramine, as they are less anticholinergic and, therefore less likely to exacerbate orthostatic hypotension during pregnancy. There is a growing literature on the reproductive safety of the newer SSRIs, and these agents may be useful in certain settings.

Electro-convulsive Therapy (ECT): Severely depressed patients with intense suicidality or psychosis require hospitalization, and electro-convulsive therapy is frequently the treatment of decision. ECT use during pregnancy is seen as safe and efficacious. There have been reports of premature work with ECT use during pregnancy. Be that as it may, there are no reports of premature rupture of layers brought about by ECT. ECT might be considered as an option in contrast to conventional pharmacotherapy for women who wish to keep away from stretched out exposure to psychotropic medications during pregnancy or for those women who neglect to react to standard antidepressant therapy.



5. Status Of Iodine Deficiency Among Pregnant Mothers In Himachal Pradesh

For the production of thyroid hormones and normal in utero neurological growth, iodine, an important micronutrient, is required. The demand of pregnant mothers for dietary iodine is higher (250 mg/d) than that of normal adults (150 mg/d). The iodine requirement is raised by 50 percent during pregnancy due to

- (i) The physiological increase in maternal and fetal thyroid hormone production and
- (ii) The increase in renal iodine loss.

Thyroid hormones are essential for the growth of the brain and neurology. The extreme form of iodine deficiency is permanent and leads to cretinism and mental retardation. If the pregnant mother is deficient in iodine, the fetal thyroid decreases thyroxine synthesis, which contributes to the fetus' mental and physical growth being impaired.

Iodine deficiency affects 2 billion individuals globally and is the largest cause of mental illness that can be avoided. 38 million newborns are affected by iodine deficiency in developing countries per year. Iodine deficiency disorders (IDD) are a public health concern in India. Of the country's 457 districts, 344 districts were surveyed for IDD, of which 263 districts were found to be IDD-endemic. A recognized endemic area of iodine deficiency is the state of Himachal Pradesh.

Studies on the status of iodine nutrition among school-age children are available in the literature; however, there is minimal data on the status of iodine nutrition among Himachal Pradesh pregnant mothers. The present study was conducted with the objective of assessing the current status of iodine nutrition among pregnant mothers in three districts of Himachal Pradesh (Kangra, Kullu and Solan), so that evidence could be given to the Himachal Pradesh State Health Authorities to improve the IDD program if appropriate.



6. Conclusion

Common mental disorders (CMDs) including depression and anxiety disorders have been reported to affect the health outcomes of both mother and child during the prenatal period. There is little data from the Lower and Middle Income Countries about the burden of CMDs during pregnancy. Growing public awareness and the likelihood of prenatally diagnosing a cytogenetic condition has increased the importance of correctly interpreting the outcome.

The results of cytogenetic analysis are published in a format defined by an international nomenclature scheme. This is easy to interpret in simple situations, but the explanation becomes complicated for the clinicians in a complex rearrangement. Practicing physicians inform the patient on the need for it before the cytogenetic test and expect a cytogeneticist to explain the findings and recommendations.

A cytogenetic laboratory is also responsible for providing this knowledge to fellow referring clinicians and even to the patient. The first part of this topic deals with the understanding and suggestion of irregular fetal cytogenetic outcomes found in constitutional chromosomal abnormalities. The following points should be understood before addressing the possibility of a particular chromosomal abnormality:

1. The recurrence risk of chromosomal disorder is extremely low if parents have normal karyotype. However, the consequences of chromosomal disorder are serious. Hence, assessing risk factor with option of prenatal diagnosis becomes important and should be offered.
2. In spite of many disorder showing familial occurrence there may not be any chromosomal abnormality; the transmission may have Mendelian inheritance.

The chromosomal abnormality found in this study is in 85 cases and that is around 7.29 percent, out of 1165 cases in total. The chance of amniocentesis procedures for global abortion is around 0.5 to 1 percent. The high percentage of chromosomal anomalies itself shows the relevance of prenatal diagnosis if we equate the abortion risk with the abnormalities found. This research found both forms of numerical and structural anomalies. The most common and highest



abnormality found in numerical anomalies is trisomy 21, followed by trisomy 18, monosomy, and sex chromosome trisomy. Autosomal chromosome inversion is the highest abnormality found in structural abnormalities, accompanied by translocation, inversion of one of the sex chromosomes, derivatives, deletion and duplication.

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