

to the SSRI's or SNRI's in the third trimester, have shown features that have included respiratory distress, cyanosis, apnoea, seizures, temperature instability, feeding difficulty, vomiting, hypoglycaemia, hypotonia, hypertonia, tremor, jitteriness, irritability or constant crying. Such complications can arise immediately upon delivery and are consistent with either a direct toxic effect, drug discontinuation syndrome or serotonin syndrome. Although not common, electroconvulsive therapy in pregnancy is a feasible option for a significant mental disorder, should all other options be inappropriate or ineffective.

Disorders presenting in the puerperium

Mental disorders occurring within 90 days of childbirth are considered to be postnatal. These disorders will most often occur during the first 4 weeks of the childbirth. The most important disorders are

- a) **MATERNITY BLUES**; lasts 3-5 days. Feelings of depression, irritability and inadequacy are common. The mood usually normalises within a few days with adequate emotional support, reassurance and practical support. Antidepressants are uncommonly indicated.
- b) **ADJUSTMENT DISORDER WITH DEPRESSED MOOD**; this is a minor depression which lasts longer and usually needs psychotherapy, intervention to improve coping skills and help with adjustments. Antidepressants are not usually indicated. Condition may negatively influence bonding between mother and baby.
- c) **POST PARTUM MAJOR DEPRESSIVE DISORDER**; some 15% of mothers develop this. Risk factors include a previous history of major depression or a family history of mood disorders. The clinical presentation of the patient will meet the criteria of a major depressive episode with or without psychotic features. This condition requires immediate involvement by a psychiatrist. Antidepressant and antipsychotic therapy is highly recommended. Psychotherapy must also take place.
- d) **POST PARTUM PSYCHOSIS**; A psychiatric emergency that occurs in 2 per 1000 mothers following childbirth and which necessitates crisis intervention. It is not a separate mental illness, but could be any one of the major psychiatric disorders precipitated by childbirth. The initial presentation usually resembles a delirium: usually sudden in onset with abnormalities of thought and behaviour developing over a few days. Auditory hallucinations, conceptual disorganisation, disorder of thought, delusions about the baby, agitation, confusion and disorientation are common. Risk factors for post partum psychosis include a history of a major psychiatric disorder, a family history of major psychiatric disorders, first baby, severe psychosocial stressors which include an unwanted pregnancy, a sick newborn baby, prolonged hospitalisation, substance abuse and acute or chronic medical illness. Diagnosis is often a problem and referral to a psychiatric unit is overwhelmingly necessary.

The Premenstrual Syndrome

The premenstrual syndrome is a constellation of symptoms related to hormonal fluctuations of the menstrual cycle. This recurrent luteal phase syndrome is characterised by "distressing physical, psychological and/or behavioural changes of sufficient severity to result in deterioration of interpersonal relationships and/or interference with normal activities". The most commonly encountered symptoms usually include: mood swings, tension, anger, irritability; headache, breast discomfort, bloating, increased appetite and food cravings

These symptoms occur during the luteal phase of the cycle and are relieved with the onset of menstruation of soon afterwards. The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders defines diagnostic criteria for a severe form of PMS, or premenstrual dysphoric disorder (PDD).

Summary of the PDD criteria

- (A) Symptoms must occur during week before menses and remit a few days after onset of menses. Five of the following symptoms must be present and at least one must be (1), (2), (3) or (4)
 1. Depressed mood
 2. Anxiety
 3. Lability
 4. Irritability
 5. Decreased interest in usual activities
 6. Difficulty in concentrating
 7. Marked lack of energy
 8. Marked change in appetite, overeating, or food cravings
 9. Hypersomnia or insomnia
 10. Sense of being overwhelmed
 11. Other physical symptoms i.e. breast tenderness and headaches
- (B) Symptoms must interfere with work, school, usual activities, or relationships
- (C) Symptoms must not merely be an exacerbation of another disorder
- (D) Criteria A, B and C must be confirmed by prospective daily ratings for at least 2 cycles

In clinical practice approximately 50% of women who have complaints of PMS actually have premenstrual exacerbation of an underlying disorder or symptoms that are not related to the menstrual cycle. Medical disorders that commonly are exacerbated during the luteal phase include migraine headaches, allergies, asthma, seizures, and genital herpes. Psychiatric conditions that can be exacerbated during the luteal phase include depression, anxiety, bulimia, substance abuse, mania and psychosis. Anxiety ratings were recently reported to be elevated during the luteal phase in women with chronic disorders and generalised anxiety disorders. Dysthymia and major depressions are also common psychiatric conditions that have premenstrual exacerbation in women claiming to have PMS.

No consistent association has been found between PMS and demographic or dietary variables, amount of exercise, level of psychosocial stress, menstrual cycle characteristics, attributions regarding menstruation or health, partner support or personality characteristics. The only clinical variable that has been consistently shown through multiple studies to be associated with PDD is an elevated prevalence of prior affective disorders, particularly major depression. PDD occurs in approximately 2 - 9% of women. A personal or family history of other depressive illnesses is also common.

Despite the relationship of the symptoms with the endocrine changes of the menstrual cycle, there is no evidence for any underlying disorder of the hypothalamo/pituitary/ovarian axis in women with PMS or PDD. There have been many theories of etiology, but current evidence suggests that PMS is a neuro-endocrine disorder caused by altered function of serotonin, probably associated with abnormalities in the norepinephrine system. This is supported by evidence that drugs that enhance serotonergic function are beneficial in its management. Having said this however, it is expected that the cause of PDD will ultimately be explained by the interaction of gonadal steroids with the neurotransmitter,