CASE REPORT

Dissociative Rejection of a Female Baby in Postpartum — A Case Report

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ABSTRACT

Mental health is linked with sociocultural issues. Gender bias is based on centuries-old religious beliefs and sayings from ancient times. Discrimination is reflected in many ways of looking after a girl child. They include denial or ignorance of female children's educational, health, nutrition, and recreational needs. Female infanticide and selective abortion of female foetuses are other forms of discrimination. Pregnancy is the most challenging part of woman. Individual's ability to get adjusted to the role transition is determined by various psycho-social and cultural factors, such as, family type, availability of family support, relationship with spouse and in laws, plans about pregnancy, gender preference and occupational stress and personality traits which makes the individual more vulnerable to develop an illness. Although there are many studies related to blues, depression and psychosis in pregnant women, there are few on dissociative episode. This case report aims at exploring the factors affecting or determining the acceptance or rejection of a new born baby in dissociative state and how the psycho-socio-cultural factors contribute to it.

KEY WORDS: Women Mental Health, Postpartum Period, Dissociative Disorders, Gender Discrimination.

Introduction

India is second most populated country in the world with more than 1350 million people. The female: male ratio as per census of India 2011 is 933:1000, which is alarming. The 2011 census report from India shows a great decline in child sex ratio (0–6 years), we can observe that there are 914 females against 1,000 males.[1] Gender bias is based on centuries-old religious beliefs and sayings from ancient times.[2] Discrimination is reflected in many ways of looking after a girl child. They include denial or ignorance of female children's educational, health, nutrition, and recreational needs. Female infanticide and selective abortion of female foetuses are other forms of discrimination.[3] Pregnancy is the most challenging part of woman. Individual's ability to get adjusted to the role transition is determined by various psycho social and cultural factors, such as, family type, availability of family support, relationship with spouse and in laws, plans about pregnancy, gender preference and occupational stress and personality traits which makes the individual more vulnerable to develop an illness.[4,5] Postpartum period is vulnerable phase for mother. The first few months postpartum carry the highest risk of both first-onset episodes and recurrence of psychiatric disorders, with the highest risk at 10–19 days postpartum.[6] Postpartum psychiatric disorders can be classified into three groups: postpartum blues; postpartum psychosis and postpartum depression.[7] Most new mothers experience mood swings, crying spells, anxiety and difficulty sleeping during their postpartum period. It typically begins within the first two to three days after delivery, and may last for up to two weeks. Global prevalence of postpartum blues is with an incidence of 300−750 per 1000 mothers. It may take a few days to a few weeks to get resolved. Postpartum depression has a global prevalence of 100−150 per 1000 births.[8] Global prevalence of postpartum psychosis, ranges from 0.89 to 2.6 per 1000 births, is a severe condition that usually begins

Access this article online

Quick Response Code:

Website: www.jmsh.ac.in

Doi: 10.46347/jmsh.2021.v07i03.003

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within two to four weeks after delivery and also as early as two to three days after delivery.[9] It requires hospitalization to ensure the safety of the mother as well as the child. Although there are many studies related to blues, depression and psychosis in pregnant women, there are few on dissociative episode. This case report aims at exploring the factors affecting or determining the acceptance or rejection of a new born baby in dissociative state and how the psycho-socio-cultural factors contribute to it.

Case Report

An emergency reference to psychiatry was made by Obstetrics and Gynaecology department in view of behavioural disturbances, disorientation and refusal of mother to feed the new born. The mother was 24 years old, first born out of two of a non-consanguineous marriage, was educated up to 10th standard, married since seven years. Patient was a homemaker. Her husband worked as restaurant manager. They had five-year old daughter.

Patient had planned pregnancy and delivered a healthy baby girl through caesarean section in middle of March 2020. She refused to accept the child and reported that she wanted to have a baby boy. Patient spoke irrelevantly and did not recognize the treating doctors and started addressing them using familiar names for example, names of her relatives. She refused to touch or feed her baby. Investigations were carried out to rule out organic causes of the behavioural disturbances. During the interview with psychiatry treating team, patient was oriented, provided informed consent and she did recognize her baby and identify the treating doctors and family members. However as she was discussing regarding the gender of the baby and her expectations, her behavioural disturbances resurfaced. Patient was prescribed Benzodiazepine, Tablet Clonazepam 0.25 mg, stat. Patient symptoms subsided in a day and no further episodes of behavioural disturbances were witnessed.

On further interview, patient reported that she was brought up in a joint family. Father had problems with alcohol use. Patient and her family were abandoned by her father at a very young age. Her aunts played a major role in her upbringing. Her mother with two daughters would frequently regret that there was no 'male' to look after her family. Her mother worked as a maid servant. Her maternal aunts supported family financially and morally. Patient got married at her will and there were no family issues and was well-adjusted with her husband. The couple had decided to have a single child and after 5 years, they decided to have another child. Though there was no pressure from husband or expectancy of her family members to have a male child, she wanted to have a 'male' child. During her pregnancy, she used to associate all her symptoms of normal pregnancy to expected gender of 'to be born' child. Few of her relatives would suggest the same. By looking at her attitude towards the 'to be born' baby, even patient's daughter would communicate her preference to have a younger brother. Patient had strong belief that her second baby would be a boy. Being pregnant she used to try some assumed methods to have a baby boy, such as having intercourse on particular days and eating sweet dishes. She denied any history suggestive of WHO -ICD 10 criteria for Acute Stress Reaction or Postpartum Blues.

During the subsequent interviews which were carried out over next two week at outpatient department she was euthymic. She was also assessed by administering Edinburgh Postnatal Depression Scale and no significance was found.

Discussion

Gender disparity and discrimination still exist in Indian society. Male dominant system has been an inevitable part of many families and continues to be practiced in many of the households. In spite of India's reputation for respecting women, to an extent to treat her as a goddess, the moment a baby is born, the first thing comes to mind is "boy or girl?" as the differences are beyond just being biological.[10] In this case, the patient had been brought up in an environment where her mother was abandoned by her father probably for not having a son. Mother may have displaced her negative emotions towards her daughters. Patient may have developed unconscious fear of similar fate as her mother if she had no male heir. So she preferred to have a 'male' child. Although the people in India have progressively changing with urbanization and education, it appears that there is still long way to go in relation to acceptance of female child at par with male child.

In this case, when the gender of newborn baby came into patient's awareness, acutely from a state of apparent good mental health state she moved to denial phase. Her refusal, confusion and misidentification for some time and complete recovery later indicates dissociate state. Dissociation has primary and secondary gain, her primary gain was probably

to avoid extreme disappointment of not having male child. Maternal intuition and beliefs on gender of the baby have got cultural importance. Cultural beliefs also contributed to her strong preference for a male child. In some culture, people tend to predict gender of 'to be born' baby if the pregnant mother has some specific features, such as tendency to sleep on left side, dark complexion, preferring sweet dishes and frequency of vomiting shows that there is a male child in the womb. Many pregnant mothers believe in more culturally traditional sex determination techniques often opined by family and friends. This case demonstrates that many people speculate on sex of unborn and socio-cultural beliefs are passed on to other families and friends.[11] There are studies that gives insight for the government in designing awareness programs and free counselling programs to persuade people with different personalities to suppress gender disappointment, thereby enhancing women's mental health.[12] It is important for treating team to understand the psycho-socio-cultural factors that contribute to dissociative state of mothers at the time of delivery. More systematic and larger number of studies is needed to understand such phenomenon in India, so that more awareness and education is provided for the pregnant women and their families.

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How to cite this article: Aithal J, Reddy S, Ekanand D, Kishor M. Dissociative Rejection of a Female Baby in Postpartum — A Case Report. J Med Sci Health 2021; 7(3):102-104

Date of submission: 15.07.2020
Date of review: 28.08.2020
Date of acceptance: 09.04.2021
Date of publication: 10.02.2022