# Perinatal Mental Health Problems –What Midwives and Nurses can do?

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## Abstract

Maternal mental health is largely neglected in low and middle income countries. There is no routine screening or treatment of maternal mental disorders in primary care settings in most parts of our country. Women of every culture, age, income level and race can develop perinatal mood or anxiety disorder. Symptoms can appear any time during pregnancy and the first 12 months after childbirth. According to the World Health Organization, worldwide about 10% of pregnant women and 13% of women who have given birth experience a mental disorder, primarily depression.

Risk factors involved in causing maternal mental health issues include previous history or family history of mental health problems, poverty, extreme stress, childhood abuse and neglect, violence, interpersonal conflict, inadequate support from family, alcohol or drug abuse, and unplanned or unwanted pregnancy, natural disasters, and negative experiences from previous pregnancies. With severe depression, the mothers fail to adequately eat, sleep, bathe or adequately care for herself or the baby. The risk of suicide or harming the baby is also possible. Prolonged or severe mental illness affects family life, hampers mother infant bonding, breastfeeding and infant care.

Specialized midwives can be effectively involved in promoting healthy pregnancies, in primary and secondary prevention, early identification, and timely provision of quality specialist care to the affected women. However, identification and management of mental disorders by non- specialized health providers is strongly recommended by the World Health Organization.

***Key Terminologies:*** *Midwives, Perinatal Mental Health, Screening, Counseling.*

## Introduction

*"There is no health without mental health"*

International Mental Health Day is observed on the 10th of October every year. Perinatal mental health as a public health issue is getting more recognition. Maternal mental health is largely neglected in low and middle income countries. There is no routine screening or treatment of maternal mental disorders in primary care settings in most parts of our country. With informed case worsening of the symptoms can be prevented with a full recovery. Midwives and nurses need to be adequately prepared to take on a more developed role in preventing, recognizing and managing perinatal mental health problems.

Perinatal mental health refers to a woman's mental health during pregnancy and the first year after childbirth. Women of every culture, age, income level and race can develop perinatal mood or anxiety disorder. Symptoms can appear any time during pregnancy and the first 12 months after childbirth.

### How serious is the problem?

Between 10 -20% of women develop a mental illness during pregnancy, or within the first year after having a baby. Depression and anxiety are the most common problems during pregnancy, with around 12% of women experiencing depression and 13% experiencing anxiety at some point [1]. In a recent experimental study, it was found that 14% of mothers showed possibility to develop postnatal depression compared to none in the

experimental group whose husbands attended Parent Preparedness Programme[2]. The study also showed strong negative correlation between scores on postnatal depression and involvement of father [2.] Suicide is an important cause of death among pregnant and post-partum women. Depression causes enormous suffering and disability and reduced response to child's needs. Evidence indicates that treating the depression of mothers leads to improved growth and development of the newborn and reduces the likelihood of diarrhoea and malnutrition among them [1].

Globally maternal mental health problems are considered as a major public health challenge. WHO advocates low cost interventions with the involvement of non-specialized or community health providers. Impact of such measures can be demonstrated not only on mothers but also on growth and development of children[3]

Examples of perinatal mental disorders include Antenatal and Postnatal mental depression, Anxiety disorders, Eating disorders, Sleep disturbance, and Post traumatic stress disorder (PTSD), Postpartum psychosis and Mania. These diseases can be mild, moderate, or severe requiring different kinds of care or treatment. Quite often these disorders go unnoticed, unrecognized, undiagnosed and untreated. If left untreated they can cause serious harm to parents and their children[4].

Mental health disorders in the perinatal period can affect the mother inadvertently. There can be increased risk of postpartum episodes, poor social functioning, and decreased productivity due to negative recognition. If left untreated, it may lead to suicidal ideation. Diarrhoeal episodes are common among babies born to the affected mothers and are usually of small birth weight with tendency for growth retardation. Poor academic performance is yet another developmental defect noted in many of these children. Due to mother's failure to keep up appointments, the vaccination status of babies of these mothers are often incomplete.

**What causes Perinatal Mental Health Disorders?**

Studies show that changes in the level of hormones during pregnancy and after birth can trigger changes in mood, whereas only some women go on to develop a perinatal mental health problem.[4]

Risk factors include marital disharmony, poverty, homelessness, extreme stress, and exposure to violence, conflict situations, natural disasters, poor social support, unwanted or unintentional pregnancy, previous negative experiences of childbirth etc. It is seen perinatal mental health disorders are more common among women with a family history of mental disorders in first degree relatives. The possibility of developing postpartum depression is 50% in women with a history of suffering from it in previous pregnancy and childbirth. A troubled marriage is often counted as a strong predisposing factor. A recent stressful experience like having a difficult and prolonged labour, emergency caesarean section, forceps/vacuum delivery, complications during delivery, and any serious birth defects or health problems in the newborn are other stressful situations.

With severe depression or even anxiety or other severe psychotic conditions, the mothers fail to adequately eat, sleep, bath or adequately care for herself or the baby. The risk of suicide or harming the baby is also possible. Suicide is a leading cause of death for women during pregnancy and in the first year following childbirth. Prolonged or severe mental illness affects the mother-infant bonding negatively. Breastfeeding and infant care also are affected. Identification and management of mental disorders in the perinatal period by non-specialized health providers is strongly recommended by the World Health Organization.

Parent education, open discussions, early assessments and intervention can reduce the risk of onset, intensification and negative effect of mental health problems[6]

Childbirth involves many psychological and emotional changes for women. The recent Commonwealth Government of Australia, National Perinatal Mental Health Action Plan recommends all pregnant and postnatal women have a psychosocial assessment including completion of the Edinburgh Postnatal Depression[7]. The future direction for improving maternity care will require midwives to assess mental health needs of women, and refer them on, for timely intervention. It is critical midwives are prepared and able to make this kind of assessment [5].

**Barriers in accessing care**

Lack of knowledge and\or experience, unclear /lack of policies, staff shortage, less time to spend with the mother, lack of tools for assessment, limited childcare facilities, poor continuity of care, poor knowledge on referral pathways are the most common reported barriers in accessing care for the affected women [8] Language barrier is reported by both women and HCPs. Differences in cultural values such as women of certain cultures insist female doctors attending them may stop them getting timely care.

**Early recognition**

At the first visit in the antenatal clinic itself, the woman can be asked if she has been feeling down, depressed or hopeless for the last one month and has little interest or pleasure in doing things. If the answer is yes, it is to be assumed that there is a clinical concern and she needs to be referred for mental consultation. If the answer is 'Yes', ask if she finds herself avoiding places or activities and does this cause her problems? If the answer is 'Yes' to the third question a detailed tool must be used for assessment eg: EPDS. A culturally sensitive tool may be prepared in local language for the initial screening as well as for detailed screening. It is also equally important to elicit any history of severe mental illness (during pregnancy or the postnatal period or at any other time). Ask for family history of mental disorders. If suggestive, refer for mental consultation.[1]

**Assessment in pregnancy and the postnatal period**

Physical wellbeing including weight, smoking, nutrition, activity level and history of any physical health problem must be assessed as a routine measure. Domestic violence and abuse, sexual abuse, trauma or childhood mal treatment are other sensitive areas to be explored. Interpersonal relationships, her attitude towards the pregnancy, including denial of pregnancy must be delved into.

**How is Postpartum Depression manifested?**

These women usually feel or look depressed, with tearfulness or crying spells. They also feel anxious, sometimes with obsessions and compulsions, often about the baby's welfare or about being able to carry out responsibilities as a mother. Feeling hopeless, worthless or guilty and feeling irritable or burdened are also noted. Sleeplessness is one of the early and common symptoms found. Losing interest or pleasure in all activities, including pleasure in being a mother is also experienced by these mothers. Changes in appetite (either overeating or not eating enough) are also common. Suicidal thoughts and or thoughts of harming the baby must be taken as very serious and need immediate steps. Fathers of new babies also can suffer from postpartum depression[1].

**What can we as Nurses do in the present Scenario?**

We acknowledge of course that the greatest burden of COVID-19 care provision, morbidity and death has fallen on those working in medicine, social care and nursing, in community care provision, in care homes, in mental health settings. Yet women and midwives remain very much affected; care during pregnancy, birth and the postnatal weeks has changed radically and fast, and basic elements of the midwife-woman relationship such as meeting in person and providing a comforting touch have been upended in an attempt to maintain distance and reduce cross-infection and also due to COVID 19, woman may not come forward with problems [11.] .As nurses we must emphasize on adequate online follow up services, online consultation and workshops through Health & Wellness Network.

Assess whether the woman has adequate social support and is aware of sources of help. If not, arrange help. Inform all relevant healthcare professionals including the nurses and midwives in the ward, nurse supervisors, treating obstetrician, consultant psychiatrist including clinical psychologist regarding the condition of the woman. The husband, parents including in-laws (consider the woman's consent) must be made aware of the condition. Advise the woman, and her partner, family or by-stander to seek further help if the situation deteriorates.

**Postpartum blues or "baby blues"**

Tend to occur in most new mothers between 4$^{th}$ to 10$^{th}$ day postpartum. The woman may be tearful, sad, irritable, anxious, and confused. These symptoms do not tend to affect the individual's ability to function. The women normally recover from these symptoms by day

10 and if prolonged may end up with PPD.[4]

**Anxiety Disorders:** Approximately 6% of pregnant women and 10% of postpartum women develop anxiety. Postpartum Panic Disorder and Postpartum Obsessive Compulsive Disorder are two forms of anxiety. The risk factors include a personal or family history of anxiety, previous perinatal depression or anxiety, stressful living situations, and thyroid imbalance. Clinical manifestations include panic attacks, constant worry, feeling that something bad is going to happen, racing thoughts, Disturbances of sleep and appetite, Inability to sit still and physical symptoms like dizziness, hot flashes, and nausea.

Managing Postpartum Depression & Anxiety Disorders include Psychotherapy (talk therapy) with educational programs and support groups. Cognitive Behavioural Therapy (CBT) is designed to help correct faulty, thought patterns. Interpersonal Therapy (IPT) can help a person sort out conflicts in important relationships or explore past events or issues. Couples Therapy can help the mother and father to plan how to manage possible areas of disagreement or how best to support each other[8].

Currently the SSRI (Selective Serotonin Reuptake Inhibitors) and SNRI (Serotonin Nor epinephrine Reuptake Inhibitors) are more commonly used compared to the old generation drugs such as MAO (Monoamine Oxidase Inhibitors) and TCA (Tricyclic Antidepressant) group of drugs as they are considered to be safer than the MAOs and TCAs. Benzodiazepines are given for short term anxiety[1].

**Alcohol, Drug misuse, Post traumatic Stress Disorder:** Refer the woman to a specialist substance misuse service for advice and treatment. Offer detoxification / de-addiction in collaboration with specialist mental health and substance misuse services. The newborn should be observed for 'withdrawal symptoms.' Only high intensity psychological (CBT) interventions are recommended for Post Traumatic Stress Disorder. **Eating disorders and sleep Disturbances** Offer a psychological intervention. Monitor the woman's condition carefully throughout pregnancy and the postnatal period. Assess the need for fetal growth scans. Discuss the importance of healthy eating during pregnancy and the postnatal period. Advise pregnant women to follow a healthy bedtime routine, avoid caffeine and reduce activity before sleep. For women with a severe or chronic sleep problem, consider promethazine.

**Postpartum Psychosis**

Postpartum psychosis occurs much more rarely and is thought to be a severe form of postpartum depression. Symptoms include delusions and hallucinations. Suicidal thoughts and or thoughts of harming the baby also are common. Severe depressive symptoms and postpartum psychosis requires immediate treatment and hospitalization. A combination of medication such as antipsychotics, mood stabilizers, and benzodiazepines, in combination with high intensity psychotherapy to control signs and symptoms are preferred. Electro Convulsive Therapy may be considered if symptoms do not subside with above management.

**Advice to Mothers with Perinatal Mental Health Problems**

Rest/sleep when baby sleeps. Do only what is needed. Get emotional support. Ventilate your feelings to someone. Enjoy social media like Whatsapp, Facebook, or Twitter. Exercise when you can. Eat a variety of healthy foods. Take care of yourself. Shower and dress each day and meet friends and relatives. Call your emergency number if you think about hurting yourself or your baby. Example. Call-112, the national emergency number. Women helpline- 1091, 181. **Prognosis:** If diagnosed and treated early, most mothers with perinatal mental health disorders recover completely. About 50% of women who recover from postpartum depression develop the illness again after future pregnancies. To decrease this risk, some doctors suggest that women with a history of postpartum depression should start antidepressants immediately after the baby is delivered, before the onset of depression symptoms..

**Advice and Information by the Midwife:** Ensure the woman understands that mental health problems are common in the perinatal period. Instill hope about the treatment of the condition. Preconception counseling for women must be planned if she has a current or past severe mental health problem and is planning a pregnancy. The potential benefits of psychological interventions and psychotropic medications must be

made clear to the woman. The possible consequences of not taking treatment regime including the possible harms associated with treatment. The woman and the family must be briefed on starting, using, and stopping treatment. Remember to appreciate the woman/parent[1].

**How Can Midwives Improve Maternal Mental Health?**

Move away from the medical model of care. Raise awareness among mothers, and family regarding any deviation in mental well being of mothers through building a trusting relationship with the woman. Always ensure continuity of care. Reduce stigma with meaningful communication. Provide supportive antenatal care to increase self-efficacy and reduce anxiety. Using customized and culturally sensitive tools to identify risk and current wellbeing can be a proactive step in identifying women at risk. If screening is indicative, refer women for additional counseling and care. Develop an evidence-based framework for maternal mental health[8].

Support family members. Find time to listen to their concerns. Do not forget mental health problems can affect fathers as well. Remember to attend ongoing training programs to update your knowledge and skill in managing perinatal mental health problems. To get a clear outlook on the issue, take up research related to maternal mental health problems. Ensure the parents get adequate antenatal parent preparation. Promote father involvement in childbirth care and empowerment and participation of mothers and families.

Use of information technology is the most effective and easiest way of maintaining continuity of care and follow up. Collaborate with the IT dept. to set up Mobile Instant Messaging (MIM). Help form WhatsApp groups of mothers with similar problems. Message on appointments, reminders, and send wishes on special days and occasions like Mother's Day, and Birthday of mother or baby. Post educational material on websites and provide web addresses to the parents. Tips to keep the baby and themselves healthy and in many more ways.

**Is it possible to prevent postpartum depression?**

*Yes, to a great extent.* All pregnant and postnatal women must have a psychosocial assessment including completion of a depression screening tool. Visit new mothers at home by a midwife/ nurse to ensure continuity of care through community health centers. Pre-pregnancy of both the parents for the early signs are some of the proactive steps and gathering history about family members would throw limelight into the possibility of the woman developing perinatal mental health problems.

**Make time to exercise.**

"Taking a brisk walk, getting fresh air, and enjoying nature can improve your outlook," says Karen Rosenthal, Ph.D., a psychologist in Westport, Connecticut A study of more than 1,000 mothers found that those who exercised before and after the birth of their baby tended to feel better emotionally and were more social than women who didn't [12]

In the context of sustained COVID-19 anxiety, we as nurses should continue to support women to have a positive pregnancy and birth with reduced visits and online breastfeeding support .We must try to ensure safe, high quality care for women and families during the COVID-19 era.

## Conclusion

Maternal mental disorders are preventable and treatable. The vast majority of future mothers do NOT require psychiatric treatment. They just need effective emotional support. Interventions aimed at strengthening mother's ability to rally social support may not only reduce early postpartum depressive symptoms but may enhance a mother's postpartum recovery. Effective interventions can be delivered even by well-trained non-specialist health providers –that includes midwives and nurses as well.

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**Certificate of Originality and Authorship**

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## References


1. NICE. Antenatal and postnatal mental health: Clinical management and service guidelines. National Institute for Health and Care Excellence. 2015.
2. Thomas S. Effectiveness of Parent Preparedness Programme in Knowledge and Involvement of First Time Fathers. Thesis submitted to RGUHS as part of Ph. D programme. Feb 2019.
3. Thinking Healthy. A manual for psychosocial management of perinatal depression. WHO.2015.
4. Perinatal mental health. Available at:www. nationalarchieves.gov.uk/doc
5. Smith M S. et al. Barrier to accessing mental health services for women with perinatal mental illness. A systematic review.BMJ.2018; 9: 1.
6. Perinatal mental health. Available at :http: // mentalhealthalliance.org
7. Mc Carley K et al. Midwives and assessment of perinatal mental health. Journal of Psychiatric and Mental Health Nursing.2011.
8. Viveiros C J, Darling K K. Barriers and facilitators in accessing perinatal mental health services: The perspectives of women receiving continuity of care in midwifery. Midwifery. 2018; 65: 8-15.
9. Myors KA. et al. Engaging women at risk for poor postnatal mental health outcomes. International Journal of Mental Health Nursing.2014.
10. Harikman S et al. Stepped care for Maternal Mental Health. Maternal Mental Health in South Africa. 2012; 9:5.
11. Marian Knight et al.Characteristics and outcomes of pregnant women admitted to hospital with confirmed SARS-CoV-2 infection in UK: national population based cohort study. BMJ. 2020.
12. Peg Rosen and Randi Hutter Epstein, M.D.Postpartum Depression. February 14, 2020. Available at: www.parents.com