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Perinatal mental health

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Introduction

Pregnancy, birth, and becoming a parent is a time of great change and adjustment. For some people this period can therefore revive or worsen pre-existing mental health problems, or act as a trigger for new mental health problems. It has been estimated that up to 20% of women develop some form of mental health problem in pregnancy or after birth and that this costs the UK £8.1 billion per annual cohort of births, which equates to approximately £10,000 per birth.¹ There is also emerging evidence that men can be affected.² For every woman who develops a severe mental health disorder there are many more women who suffer from moderate symptoms which can still be distressing and have a negative impact on women and their families. Mental health and illness are therefore not categorical but more like a continuum from positive mental health to severe illness. Women can fall anywhere on this continuum and move up or down depending on events and circumstances.

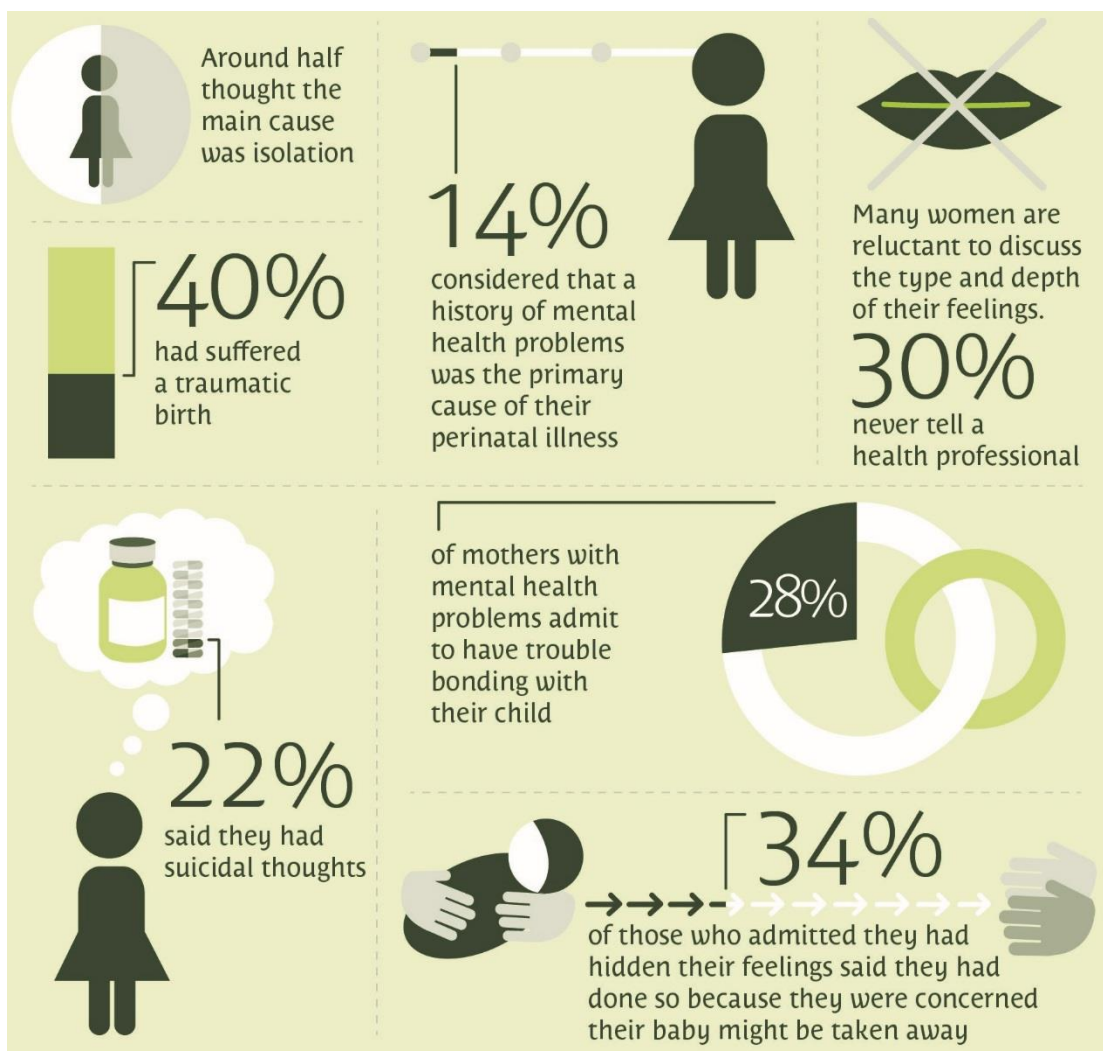
Many different types of mental health problems can arise during this time. The most severe disorder is puerperal psychosis, which occurs in 0.1% of women. Women with puerperal psychosis are at high risk of harming themselves and their baby so require immediate hospitalisation. Women are more at risk of puerperal psychosis if they have a personal or family history of psychosis or bipolar disorder. The most common perinatal mental health problems are depression and anxiety, which affect between 10 and 15% of women in pregnancy and after birth.³ However, there are many other disorders that are often missed because professionals who work in perinatal services are less aware of them. These include posttraumatic stress disorder (PTSD), obsessive compulsive disorder (OCD), phobias, panic, adjustment problems, bi-polar disorder and bonding disorders. These disorders are not as common as depression and anxiety but still affect a large number of women. For example, 3-4% of women will develop PTSD following a traumatic birth, which equates to at least 21,000 women per year in the UK.⁴ Birth-related PTSD is particularly interesting because of the possibility to prevent it through antenatal preparation and appropriate support and care during birth. Risk factors for birth-related PTSD are depression during pregnancy, fear of childbirth, negative experiences during birth, an assisted or caesarean birth, poor support, and dissociation during birth.⁵

A number of general risk factors make it more likely that women will have perinatal mental health problems. Some of these risk factors are remarkably consistent across different cultures and different mental health problems. For example, mental health problems are more likely to occur if women live in social adversity (e.g. deprivation, low socio-economic status, domestic violence), have a history of psychological problems or childhood adversity, and poor social support.⁶ In addition, if

women are anxious or depressed during pregnancy this is a risk factor for continued mental health problems postpartum.⁶

Signs that a woman may have perinatal mental health problems vary. Severe disorders, such as psychosis or bipolar disorder, are usually very noticeable and symptoms include (but are not limited to) delusions, mania, confused thought and paranoia. The more common affective disorders can be harder to spot because women may hide their problems through shame, stigma, or fear their baby will be taken away. Figure 1 shows the results of an online survey of 1,500 women who experienced perinatal mental health problems. In this survey 30% of women never spoke to a healthcare professional and a third of these women hid their feelings because they were concerned their baby would be taken away.⁷

Figure 1. Perinatal Mental Health Survey (reproduced with kind permission from the Boots Family Trust Alliance)



Women with perinatal mental health problems frequently withdraw from social interaction so if a woman stops going out, rarely socialises, cancels or misses repeated appointments, it could be a sign that she has perinatal mental health problems. Common signs to look out for are if women are flat emotionally or tearful, which could be a sign of depression, or have excessive or uncontrollable worry, which is a common symptom of anxiety disorders. Key symptoms of PTSD are intrusive thoughts, nightmares or flashbacks about the traumatic event. Many women with PTSD also suffer from depression which means that in some cases the depression is picked up first. Recommended treatments differ for different disorders so it is important to check for a range of symptoms. However, until recently maternity services only screened for depression. Latest NICE guidelines recommend screening for depression and anxiety but this will not pick up all the women with less recognised disorders.

The impact of perinatal mental health problems

Mental health problems during and after pregnancy are important because of the negative impact they have on women and their families. This is illustrated in Figure 1, which shows that 22% of women in this survey said they had thought about suicide, and 28% said they had problems bonding with their baby. This is consistent with the broader literature, where perinatal mental illness is a key indirect cause of maternal death.⁸ Qualitative studies suggest wide-ranging effects on women and their families. For example, an interview study with women who had birth-related PTSD found women reported changes in physical wellbeing, mood, behaviour, social interaction, fear of subsequent childbirth, as well as negative effects on their relationship with their partner such as sexual dysfunction, disagreements, and blame for events of birth.⁹

Perinatal mental health problems can also have a significant impact on the baby. Women's mental health during pregnancy can affect the developing foetus through neuro-biological foetal programming which can have a long term effect on the child's development and health.¹⁰ Infants of mothers who are stressed and anxious in pregnancy show more fearful behaviour and increased physiological stress responses. Longer term, anxiety and depression in pregnancy are associated with poor emotional and behavioural development which can persist into adolescence. For example, a study of 7,944 families in England showed maternal anxiety and depression in pregnancy is associated with a child being twice as likely to have a mental disorder.¹¹

Vulnerability to mental health problems can therefore be transmitted from one generation to the next. This intergenerational transmission of vulnerability is due to many factors such as epigenetic

mechanisms, exposure to difficult circumstances and adversity, and parental mental health and parenting styles which influence how infants respond to events and regulate their emotions.¹² After birth, mental health problems can impact on the relationship between a mother and her baby. There is evidence that women with postnatal depression are less sensitive to their baby's emotional state and may have problems parenting, such as being withdrawn and unavailable to the baby or over-intrusive. These babies are therefore more likely to develop an insecure or disorganised attachment style, which in turn is associated with poor mental health in childhood and adulthood.¹³ Gender is also a risk factor with boys appearing to be more adversely affected than girls.¹⁴ These are just some of the mechanisms through which mental health problems and social adversity can be transmitted from one generation to the next.

Women's partners can also be affected. During this time couples' mental health is interlinked with one partner's emotion health being significantly associated with the other.¹⁵ There is emerging evidence that men can suffer from a range of perinatal mental health problems themselves, including anxiety, depression and PTSD symptoms through witnessing a traumatic birth.² However, it is not clear how many men are affected or whether men express mental illness differently to women at this time. This is an area where a lot more research is needed.

The impact of perinatal mental health problems on a couple's relationship has been less examined but there are case studies and qualitative studies illustrating the impact of conditions such as postnatal depression and PTSD upon relationships. For example, postnatal depression is associated with a greater decline in relationship satisfaction during the transition to parenthood than usual and a deterioration in the couple's relationship.¹⁶ Women report a loss of desire to be around a partner or have sex,¹⁷ lack of understanding from partners,¹⁸ ignorance of concerns,¹⁹ problems with communication, and arguments.²⁰ Research on the impact of PTSD on a couple's relationship shows a similar pattern with increased strain on the relationship,²¹ sexual problems,²² anger and blame,⁹ problems with communication and arguments,²³ unwillingness to have subsequent children because of fear of childbirth,²⁴ and relationship breakdown.²⁵

Treatment and interventions at this time are important to prevent the negative impact of perinatal mental health problems on the individual, couple's relationship, and baby. Progress in this regard is patchy, with a recent report showing very few areas in the UK have adequate perinatal mental health services.²⁶ More advances have been made in providing parenting interventions, some of which have been shown to be effective at improving parenting and secure attachment in infants.²⁷

The impact of perinatal mental health problems on families shows how important it is that interventions consider the family and help strengthen couple relationships.²⁸ It is also important that interventions with parents at this time are evaluated to ensure they are effective.

What can NCT practitioners do?

There are many ways in which NCT practitioners can help prevent or reduce perinatal mental health problems. In terms of prevention, practitioners can facilitate open discussions about mental health to help normalise such problems and reduce perceived stigma. The fact that NCT services are usually separate to NHS services may mean couples see it as a safe space in which they feel more able to discuss problems. Research shows women are more likely to talk about perinatal mental health problems if they know and trust the professional they are talking to.¹⁴

In terms of treatment, practitioners are well placed to identify women and men who have perinatal mental health problems and signpost them to help, advice and services. This is especially valuable given the great variation in services in different areas of the UK.²⁶ If practitioners are familiar with local services and have contacts within these services it can help parents access treatment more easily and quickly. This knowledge of local services is invaluable in signposting parents to available services. In addition, there are national services parents can access, such as Improving Access to Psychological Therapies (www.iapt.nhs.uk); as well as online therapy courses for people with mild or moderate symptoms, such as the Netmums 'Helping with Depression' course (<http://www.netmums.com/parenting-support/depression-and-anxiety/helping-depression-sign-up>). A review of online therapy for perinatal mental health found it may be particularly effective for women with postnatal depression.²⁹

Figure 2 illustrates some of the ways practitioners can help in terms of raising awareness, educating and empowering clients, developing self-supporting groups of parents, and signposting services. When providing support for people with perinatal mental health problems it is important that there are clear boundaries to protect both practitioners and clients. NCT practitioners are there to support and signpost parents to services but not to diagnose or counsel. It can be emotionally draining supporting people with perinatal mental health problems so it is crucial that practitioners have access to their own support such as mentoring and supervision.

Figure 2. Potential role of practitioners in perinatal mental health



If practitioners are aware of the range of perinatal mental illnesses and potential impact upon families this knowledge can be filtered through to parents. Practitioners can raise awareness, begin to normalise and reduce stigma for perinatal mental illness, therein breaking down some of the barriers to accessing support.³⁰ Figure 3 summarises key actions suggested by NCT expert practitioners for trying to prevent or reduce birth trauma, many of which are relevant for perinatal mental health more generally. This outlines possible ways to increase awareness, confidence and empower parents in pregnancy; and to support those after birth who develop mental health problems and make sure they access help.³¹

Social support is critical in good mental health so developing bonded, self-supporting client groups can provide invaluable peer support and friendships.³² Antenatal teachers may like to consider the use of single sex classes which provide a peer-based platform for deeper understanding of emotional and wellbeing topics, which may be especially beneficial for men.³² NCT doulas and breastfeeding counsellors have a key role in supporting parents through the birthing process and early parenting so are well placed to identify and support parents who experience mental health problems.^{33,34}

Similarly looking at provision and content of courses may enable practitioners to better support parents with previous or current perinatal mental health problems, particularly those who have traumatic birth experiences. Reunions are an integral part of antenatal courses and practitioners facilitating reunions could reflect on the structure of these sessions to ensure that there is time and space for parents to talk about their birth experiences (if they wish) and therefore gain acknowledgement and suitable signposts to support.³⁵ Local branch activities and postnatal Early Days courses provide a valuable opportunity to signpost services to parents experiencing mental health difficulties. Practitioners may want to develop their practice further (or promote the practice

of a fellow practitioner) in areas such as relax stretch and breathe, yoga for pregnancy and baby massage. These courses allow NCT to extend its reach in terms of the timescales of working with women, as well as working with women from wider demographic backgrounds.

Figure 3. Practitioners' tool-kit to prevent or reduce birth trauma



Summary and conclusion

In summary, perinatal mental health problems affect up to 20% of women in pregnancy or after birth. Men can also be affected, although there is not enough evidence to be able to say how many. Perinatal mental health problems are numerous and include psychosis, anxiety, depression, as well as less well-recognised problems such as PTSD, OCD, phobias, panic, adjustment and bonding problems. Although recommended treatment pathways are available for the most severe and common disorders, there is huge regional variation in services. Stigma and other concerns mean women and men might not disclose their mental health problems or access services. In addition, those with mild or moderate symptoms may not meet the threshold for referral to psychological services. NCT practitioners are well placed to raise awareness in parents about perinatal mental health, reduce stigma, identify parents with perinatal mental health problems, and provide advice and support. A number of ways in which NCT practitioners could help have been outlined in this article. It is important that support is also available to practitioners to help them develop their skills in recognising and managing perinatal mental health problems, as well as in safeguarding issues.

Finally, it is important for evaluation to be an integral part of interventions to help us provide effective prevention and treatment programmes for perinatal mental health problems.

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Word Cloud – Tool Kit for preventing Birth Trauma



Word Cloud – Tool Kit for overcoming Birth Trauma

