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MENTAL HEALTH DURING PREGNANCY AND THE POST-NATAL PERIOD

Mental health during pregnancy and the post-natal period is often treated as a taboo subject, especially by those who are suffering. Some people think that having a mental health problem is a reflection on their parenting ability. Others fear that reporting their concerns will lead to the removal of their new child by social services.

Thankfully, these lines of thinking are not based on fact. Social services worldwide want children and parents to stay together as often as possible, and they understand that parental ability is not determined by mental health. Unfortunately, treating the subject as taboo means that many sufferers do not seek the treatment they require at early stages and often suffer unnecessarily.

With this leaflet, we'll talk you through a number of mental health conditions that affect new mothers. If you are expecting a baby, try not to worry. As a new parent, it is good to be mindful of these things. And, what everyone reading this needs to know is, these conditions are treatable. Never, ever feel ashamed if you are suffering. You are not alone; there are many people, all over the world, in a similar position to you.

Throughout this leaflet we will be using the terms post-natal and pregnancy. In many instances these terms are interchangeable and can also reflect other phrases such as postpartum, antenatal or prenatal, that all relate to various stages of the pregnancy cycle. Whilst there may be certain scenarios that only occur in one stage of pregnancy, there is general agreement in the field that you can use any of these terms when referencing the whole of pregnancy.

Mental health problems in the pregnancy and post-natal period do not affect all new parents but are thought to impact anywhere from 10% to 20% of women during pregnancy and the following first year after having a baby (GOV UK, 2019), with the risk being higher in developing countries. This mental health problem may not be specific to the pregnancy or the child and may be another episode of a pre-existing condition. Unfortunately, a history of severe mental health problems does put a person at more of a risk of developing symptoms during pregnancy with these conditions often progressing more quickly than before. It is therefore useful to discuss all previous mental health conditions with your primary care provider during your pregnancy so you can plan for any potential re-emergence of symptoms. It is also important to note here that every person is different and that having previously had a mental illness does not guarantee you will suffer again during your pregnancy, just that you may have an increased risk.

One of your first appointments prior to the birth will probably cover your mental health history, but if it doesn't, don't be afraid to raise the issue with your care provider. Please remember - most mental health problems are manageable and treatable with some form of psychological therapy, without medication (so there won't be any risk to your unborn baby). If medication is required, your primary physician will work with you to establish a suitable dosage. Please remember that if you are put on any medication during your pregnancy, it's important to discuss stopping your medication or any changes to dosage before acting in order to avoid causing any harm to yourself or your child.

Regularly occurring conditions in pregnancy and post-pregnancy

We'll briefly outline a number of conditions, as well as showing how common they are, and what the recommended treatments are likely to be. It is common for people to refer to 'Baby Blues' but, as this occurs so frequently, it is not classified as a condition, and does not require treatment. The 'Baby Blues' involves feeling down, anxious or tearful in the two weeks following the birth of a child. If you are experiencing these feelings, then they will likely pass on their own. But if you find the symptoms are persisting past the two-week mark, then you should consult your care provider.

Bonding

When discussing the treatment of mental health problems, people are often concerned about their ability to bond with their child. When we talk of bonding we are referring to the intense emotional connection that a parent feels for a child, which may start at birth, or prior to birth. Some parents feel this immediately, but for others, it may take a little time so that they only feel the bonding process begin once they have come to know their baby a little better. For some, the prospect that they might not bond with their child straightaway can be scary, but this is normal and bonding will occur with time. Many hospitals do try to encourage the bonding process from birth, providing time for the baby and mother to be left alone soon after birth to begin this process. In other instances, where contact may be delayed, skin to skin contact is promoted at the earliest opportunity.

You may be reading about these mental health problems in pregnancy and the post-natal period and worry how they will affect your bonding period, especially if a hospital stay is required. Try not to worry; the bonding process will still be begun as soon as possible, leading to a normal parent-child relationship. In fact, many mental health facilities have dedicated mother and baby units to allow a mother to receive treatment in hospital with their baby staying with them, allowing as much contact as possible during the treatment process.

Post-natal Depression

Post-natal depression (PND) is probably the mental health condition that most people think of in connection with pregnancy. As the name suggests PND is a type of depression that is experienced after the birth of a child. Many people are unaware that they are suffering from PND as the onset is often more of a gradual decline. Some symptoms of PND to look out for include feeling sad or hopeless, a loss of appetite and a lack of interest in doing things you previously found enjoyable. The onset of PND usually occurs within the first six months of the child's birth, and in some cases, can last over a year if left untreated.

PND is highly treatable and can be tackled using self-help techniques, psychotherapy and medication. The medications used are part of the antidepressant family and psychotherapy is likely to include Cognitive Behavioural Therapy which helps a person identify their negative thought patterns and behaviours, and then works to find ways to adapt them. In many cases, antidepressants and psychotherapy will be implemented in unison. You may also be able to use self-help techniques and lifestyle changes to combat your PND, although we would still suggest consulting your medical care provider for an official assessment before completely writing off therapy. Some effective lifestyle changes are making time to relax and reducing excessive caffeine and alcohol consumption. It is certainly beneficial to avoid being overly self-critical. And many people also benefit from confiding in a family member of partner, whilst others may benefit from local support groups or online message boards. Above all, it is important to avoid isolation. Postnatal depression affects approximately 1 in 10 women in developed countries (Netsi et al., 2018) and it affects 13-19% of all pregnant women (Rollè et al., 2020). Half of all postpartum major depressive episodes will begin before the delivery occurs (APA, 2013).

Post-natal Psychosis

Post-natal Psychosis, often referred to as Postpartum Psychosis, is a serious mental health condition that can cause hallucinations and delusions.

Hallucinations often include hearing voices or seeing things that aren't perceived by others, whereas delusions are thoughts or beliefs that aren't true. In some instances, these delusions can become paranoid, leading the person to believe somebody is out to harm them or their new baby. Post-natal Psychosis can also lead to mood changes and can result in the harm of both the sufferer and their new baby. Sadly, in most cases, the sufferer is unlikely to realise that they are unwell, so they may not seek out treatment for themselves. It is important that the people around the sufferer treat psychosis as a medical emergency and seek help on their behalf as soon as possible.

The treatment for Post-natal Psychosis is likely to include anti- depressants, anti-psychotics and mood stabilisers. In some cases, treatment may require a hospital admission, in these instances many services offer a mother and baby unit to allow the bonding process to continue as much as possible. The majority of women will start to show signs of recovery quickly after starting treatment. In some cases, mothers may struggle to bond with their new child after a bout of psychosis, but with enough support and the right care, these mothers will go on to form normal, healthy relationships with their children.

A person may find that once the symptoms of Psychosis have been treated, they experience a period of depression and anxiety, but with the right follow up treatment this will also be treatable.

The risk of Post-natal Psychosis is estimated to be approximately 1 to 2 in 1000 women (GOV UK, 2019). As with a number of conditions, the risk for Post-natal Psychosis is increased if you have previously suffered from psychosis or a serious mental health condition. Unfortunately, estimates suggest that half of women who have had Post-natal Psychosis will go on to have another episode in future. You are also at a greater risk if you have previously suffered from Bipolar Disorder, Schizophrenia, Schizoaffective Disorder or any psychotic illness. Having a direct relative who has had Post-natal Psychosis also puts a person at a higher risk of experiencing this condition.

It is therefore important to highlight any potential risk factors that may impact your pregnancy as early into the pregnancy as possible so that you and your doctors can discuss your risks, medications and potential treatment plans if symptoms do arise.

Post-natal OCD

Post-natal OCD is when a person experiences symptoms of Obsessive- Compulsive Disorder around the time of pregnancy and childbirth. As the name suggests, the sufferer experiences unwanted obsessions and compulsions. In Post-natal OCD these tend to revolve around your child and concerns about becoming a parent. Common obsessions include intrusive thoughts about harming your baby, or giving your new baby a severe disease. Common compulsions include excessive cleaning of the baby's toys and constant checking of the infant. Whilst most new parents will check on their child regularly, those suffering from post-natal OCD will do it to the extent that it is impeding their day- to-day lives and causing distress.

Women suffering from intrusive thoughts are often understandably distressed by them, and can be quite secretive about sharing their thoughts with others, including health care professionals. What is important to remember here is that having intrusive thoughts does not mean a person will act on them. (The fact the people are disgusted or ashamed of their thoughts cements this theory.)

When looking at treating a person's OCD, a combination of medication and psychotherapy are likely to be used, including the use of Selective Serotonin Reuptake Inhibitors and Cognitive Behavioural Therapy (CBT). As with all medications during pregnancy, your regular health care provider will likely want to monitor you closely to ensure your baby remains healthy whilst you receive treatment. CBT helps to identify a person's negative thought patterns and behaviours and looks to find alternative ways of thinking. CBT for OCD is also likely to involve Exposure Response Therapy which has had great success in the treatment of OCD. Approximately 1.7%-4.0% of women have their first onset of OCD after giving birth (Sharma, & Sommerdyk, 2015).

Tokophobia (The fear of giving birth)

Tokophobia is a condition where women fear giving birth, and it may affect both those who have previously had a child (Secondary

Tokophobia), and those who have never given birth, (Primary Tokophobia). There can be a number of risk factors leading to Tokophobia, including previous symptoms of OCD or experiences of sexual assault, and symptoms may occur as early as adolescence. A previously traumatic birth is often the cause of Secondary Tokophobia.

Whilst most women will experience some fear or anxiety prior to the birthing experience, this will not reach the threshold for a classification of Tokophobia and will resolve itself. However, those who are suffering are likely to experience such an immense fear of giving birth that they may elect to completely forgo having children or favour a Caesarean Section over a natural vaginal birth. For those that have previously had a traumatic birth experience in a hospital, Tokophobia may manifest in a desire for a home birth. Fortunately, talking therapies and counselling have been found to be successful in relieving the symptoms of

Tokophobia and, even if they are not successful, women can then opt for a voluntary Caesarean Section, or home birthing experience. However, it is always advised to seek treatment prior to deciding your birthing plan if you are experiencing Tokophobia symptoms, and always consult with the health care professional in charge of your birthing experience.

Because Tokophobia is not an official diagnosis in many places, it makes accurate data gathering complicated, in addition to this being a rare phobic disorder (Mayor, 2018). Additionally, many women suffer from fears that do not reach a clinical level; however, study estimates from a sample in London suggest that the severe fear of childbirth affects 3.7% of women (Mayor, 2018).

Post-natal PTSD

Post-natal Post Traumatic Stress Disorder (PTSD), sometimes referred to as birth trauma, is a disorder that is often the result of an unexpected traumatic birth experience such as an extended labour period, an unplanned Caesarean Section, or a shocking experience during the birthing process. It may also be related to a traumatic gynaecological procedure. Post-natal PTSD can cause a range of feelings and emotions, such as disappointment with the way the birth happened, which can, unfortunately impact on the relationships with the baby. PTSD also causes unwanted memories and flashbacks of the traumatic experience which can greatly impact daily life. These symptoms of PTSD may occur immediately after the birth of the child, but in some cases, onset is delayed by a number of months. Once symptoms do occur they are likely to lead to isolation, fear of sex, avoidance of medical procedures and may cause bonding problems between the mother and baby.

Fortunately, post-natal PTSD is a treatable condition and will often be treated with talking therapies such as Cognitive Behavioural Therapy. In some cases, especially when a person is having trouble discussing their feelings, another treatment known as Eye Movement Desensitisation and Reprocessing (EMDR) may be employed. Medication may also be prescribed, but this will be for associated conditions as there is no PTSD-specific drug.

Speaking broadly, post-natal PTSD is estimated to affect anywhere from 1%-30% of women (Dekel, Stuebe, & Dishy, 2017), with as many as one third of women claiming that their delivery was psychologically traumatic (Dekel et al., 2017).

Post-natal mental health in fathers and partners

Although fathers and partners cannot currently receive a formal diagnosis in many regions, it is widely recognised that it's not just mothers who suffer from post-natal conditions. Fathers and partners can also suffer from a number of conditions, including depression and OCD. This isn't surprising given that depression is often the result of emotional and stressful events; having a baby can obviously be challenging and unsettling.

A new baby is also likely to cause greater financial stress, as well as a change in lifestyle, and a change in relationship roles at home, all of which can put a strain on a person's mental health. This is all occurring at a time when a husband or partner is also concerned for the welfare of their partner who has just been through the birthing process and may still be recovering. A person's risk for suffering from mental health problems in the post-natal period seem to be dramatically increased if the mother of the new born is also suffering from a condition such as Post-natal depression, or if the mother-father relationship was strained prior to the birth of the child. This is again exacerbated if the father is younger in age and less financially stable. Fathers and partners are also able to receive treatment for conditions such as OCD or depression, usually through Cognitive-Behavioural Therapy and medications. Couples with strained relationships may also benefit from attending sessions as a couple to work on maintaining a relationship that helps the mental health of all involved.

Estimates suggest that more than one-in-three new fathers are concerned about their mental health in some capacity. Building on this, studies have found that between one-in-ten and one-in-five new fathers suffer from Post-natal depression and fathers tend to be more at risk in the three-to-six month period after the birth of the child. When looking at OCD in new fathers, researchers have found that two thirds reported scary negative thoughts regarding their children, (although in this study they did not reach clinical levels, it was noted that instances of severe clinical OCD have been seen in new fathers). This highlights the need for support – aimed not only at new mothers but at the family unit as a whole – to be implemented more regularly, to ensure all those who need help get the help they need.

What should you do if you are suffering?

If you do feel that you are suffering from a mental health problem during your pregnancy or your post-natal period then it is important to take action as soon as possible. You may want to start by confiding in a close relative or partner, or consulting your health care professional or midwife. Unfortunately, when prospective mothers or new mothers feel they are suffering from a problem they incorrectly interpret this as a reflection of their suitability to be a mother. It is important to emphasise that this is far from the truth. A mental health problem is not in any way a reflection of a person's ability to be a parent. However, it is this misinterpretation that can cause many mothers to delay seeking the help that they need. The problem this causes is that, whilst most conditions are treatable, people suffer in silence while their conditions worsen. The earlier treatment is sought, the easier it is likely to be to treat, and the quicker you can return to your normal self.

In some cases, a partner will notice a decline in the mental health of the pregnant mother, or mother-to-be, before they themselves are aware of it. This is frequently the case in instances of post-natal psychosis. In these instances, as a partner, you will need to remain compassionate and supportive when broaching this subject. If possible you will want to discuss your concerns with your partner and consider talking with your regular health care professional together. In some cases of psychosis, you may not be able to talk with your partner and will need to go to your health care provider directly, as psychosis should be treated as a medical emergency. While you may be apprehensive about directly contacting your health care provider, it is important to remember that you're doing it for the health and safety of your partner and your child. In the long term, doing this will help return your partner to a healthy state more quickly.

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