Mental health challenges among pregnant women – what clinicians need to know

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With anxiety and depression most widely reported during pregnancy, it is important to identify pregnant women with mood disorders because untreated depression can have devastating effects on both the mother and the unborn child. Mothers who suffer from these mental disorders may not be able to function properly and this may adversely affect the mother-infant bond. When poorly treated, maternal mental disorders are associated with lower Apgar scores, decreased birth length, low birth weight, psychiatric morbidity later in life, and increased risk of behavioural disorders. Pharmacological treatments such as antidepressants are needed after careful and strategic collaborative analysis of both the risks and the benefits to the patient. Moreover, non-pharmacological interventions have been shown to reduce the severity of depressive symptoms in pregnancy, but research is limited within this field and needs clearer evidence. Barriers to accessing maternal mental healthcare such as lack of routine screening for mental health care at antenatal clinics, and stigmatisation of mental illness have been identified. Facilitators include positive healthcare providers' attitudes towards mental illness; being open, ready to listen, and having a non-judgmental attitude. Additionally, ensuring guidelines on best practices for routine screening are available during regular maternity check-ups in maternity settings can improve maternal wellbeing. Periodic capacity training on maternal mental disorders for healthcare providers is necessary to create awareness to promote safe motherhood. Antenatal depression and anxiety symptoms can effectively be detected and treated early whether mild, moderate, or severe with proper guidelines for obstetricians and midwives in the obstetric settings.

Keywords: prenatal, anxiety, depression, mental health challenges, midwives

Prof Nurs Today 2024;28(1):21-23

Introduction

Pregnancy is seen as a time of great joy but it is also associated with stress and anxiety. Globally, it is estimated that mental disorders affect one in every five women during pregnancy.[1] The prenatal period has been described as the most appropriate time to screen, detect, diagnose, and treat common mental disorders because of the regular contact between pregnant women and healthcare professionals.[2] Although regular antenatal visits are seen as an opportune time and setting, common maternal mental disorders are still under-recognised, underdiagnosed, and under-treated.[3] With anxiety and depression most widely reported, it is important to identify pregnant women with mood disorders because untreated depression can have devastating effects on both the mother and the unborn child.[4] The prenatal period is seen as having greater susceptibility to the occurrence of sleep and appetite changes, psychological mood disorders like extreme sadness, feelings of guilt, and worthlessness with suicidal ideation.[5] Moreover, pregnant women who isolate and refuse to share symptoms of sadness and irritability because of society's expectations of pregnancy as a time of joy may tend to consider emotional disturbance as part of the hormonal changes that normally occur in pregnancy.[6]

Studies from low- to middle-income countries have also shown strong evidence from primary healthcare settings of the mistreatment of pregnant women by midwives in Ghana, Guinea, Tanzania and Ethiopia.[7-10] These serve as key deterrents to early antenatal care seeking and low utilisation of maternity services, thus affect the psychological wellbeing of the pregnant woman.[11] A systematic review by Minckas et al. (2021) has also shown that poor perinatal mental outcome is linked with disrespect, maltreatment, and verbal abuse experienced in the healthcare system during pregnancy and childbirth.[12]

Despite the negative impact of common mental disorders occurring in the prenatal period and its repercussions on the affected woman, child, her family and social life, the understanding of perinatal mental issues among health professionals, especially in low- to middle-income countries is very low compared to those in high-income countries.[5,13] Literature centred on prenatal mental health challenges are scanty, therefore this review aims to provide insight and contribute towards bridging the knowledge gap.

Depression and anxiety in pregnancy

Most women may experience depression for the first time during pregnancy whereas others with a previous history of depression may be at an increased risk of relapse.[14] Research has found that the absence of uniformly effective therapeutics (both pharmacological and non-pharmacological treatments) with guaranteed mother and foetal safety makes treatment of depression during pregnancy challenging.[15] Studies have found that a history of abuse, unplanned pregnancy, poor physical health before pregnancy, poor social support and a history of previous miscarriages are triggers of antenatal depression.[16,17] Anxiety, depression and bodily disorders in pregnancy are known risk factors for maternal suicide.[18] Evidence suggests that antenatal mood disorders such as depression and anxiety are associated with reduced antenatal clinic attendance, inadequate nutritional intake, increased risk of pre-eclampsia and increased risk of preterm birth.[19,20]

Symptoms identification in pregnancy

The main signs and symptoms of mental disorders in pregnancy are low mood and loss of interest in pleasurable activities. Therefore, persistency of symptoms helps to distinguish depression from temporary response to stress or sadness. The International Classification of Diseases (10th edition) ICD-10 has no antenatal specifier for depression. However, the Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5), denotes a *"with perinatal onset"* specifier for major depressive episodes with onset during pregnancy or within four weeks postpartum.[21] ICD-10 criteria include two-weeks of at least loss of interest and enjoyment and reduced energy leading to increased fatigue and diminished activity.[22] The DSM-5 (2013) criteria depressive episode shows that the individual should demonstrate at least five of the following:

- Noticeably diminished interest or pleasure in all or almost all activities most of the day
- Fatigue or loss of energy nearly every day
- Psychomotor agitation or retardation nearly every day
- Feelings of worthlessness
- Excessive or inappropriate guilt (which may be delusional) nearly every day
- Intense moodiness
- Neglect of personal hygiene
- Weight loss
- Insomnia/hypersomnia
- Loss of concentration
- Self-harming or infanticide

Impact of maternal mental health challenges on child

Recent literature reported that anxiety and depression in pregnancy are associated with the child being twice as likely to have a mental illness themselves.[23] Negative outcomes affect the child's cognitive development, language, psychological and behavioural issues.[23] Mothers who suffer from mental disorders may not be able to function properly and this may adversely affect the mother-infant bond.[24] Mental disorders are known to diminish a mother's capacity in caring for her child thereby affecting the child's nutrition negatively.[25] Mental disorders are common among mothers of children under five particularly in developing countries and have both physical and psychological effects.

Physical effects

When poorly treated, maternal mental disorders have been associated with lower Apgar scores, decreased birth length, low birth weight, psychiatric morbidity later in life and increased risk of behavioural disorders. Children of mothers with mental disorders usually suffer from diarrhoea, infection, malnutrition with child stunting and being underweight, delayed social and communication skills, impaired bonding and also decreased immune function.[25-30]

Psychological effects

Maternal mental disorders are known to have influences on the brain structure and function of children in early life.[31] Current literature shows that there is an association between maternal depressive symptoms and children's brain development as there may be deficit in emotion processing and neurological development.[32]

Treatment of common mental disorders during pregnancy

Pharmacological treatment

A systematic review on antidepressants found selective serotonin reuptake inhibitors (SSRI) as most favourable since they serve as first-line pharmacological treatment for major depression in pregnancy.[33] Effective doses of antidepressants are needed after careful and strategic collaborative analysis of both the risk and the benefits to patient.[34] Pharmacological treatment of depression during pregnancy and lactation have mostly centred on SSRI, including adequate monitoring.[35] Research has shown that citalopram (Celexa) and sertraline (Zoloft) are the preferred medications usually prescribed by obstetricians during the perinatal period as breastfeeding is encouraged with Sertraline.[36]

Non-pharmacological treatment

Non-pharmacological treatments like mind-body interventions which include relaxation techniques like, for example, listening to music, guided imagery as well as mindfulness-based physical activity like yoga are useful in the treatment of pregnancy-related anxiety. Non-pharmacological interventions have been shown to reduce the severity of depressive symptoms in pregnancy

Table I: Barriers and facilitators/enablers to mental health services during the perinatal period[4,23,39,40]

Barriers	Facilitators /Enablers
Unclear policies, lack of mother-centred antenatal care.	Flexible and woman-centred care in antenatal clinics.
Inadequate resources, service fragmentation.	Clear workflow procedures in care settings with available resources and service integration.
Stigmatisation towards mental illness by healthcare providers.	Positive healthcare providers' attitude towards mental illness – being open, ready to listen with non-judgmental attitude.
Language/cultural barriers between pregnant women and health providers (nurse and midwives) that delay identification of mental illness.	Centering women's health within a context of cultural humility (examining one's own cultural beliefs and identities). Midwives' and nurses' approachability, ability to perceive and development of a trusting relationship improves.
Insufficient knowledge of maternal mental health among healthcare providers.	Capacity training on maternal mental health for healthcare providers to improve their knowledge.
Inability of healthcare providers to recognise and address their own mental health challenges that limit their ability to engage pregnant women on their mental health issues.	Increasing mental wellbeing of healthcare providers through counselling support at the workplace.
Lack of routine screening for mental healthcare at antenatal clinics.	Guidelines on best practices regarding routine screening during regular maternity check-ups in the maternity settings.

but research is limited within this field and need clearer evidence.[37] Alternatively, a previous study also discovered that non-pharmacological interventions such as psychoeducation, psychotherapy and cognitive behavioural therapy (CBT) should be recommended as the initial treatment for mild to moderate depression in pregnancy.[4,36] CBT, exercise and physiotherapy have also been found to be effective in managing maternal depression and anxiety and these interventions are less costly.[38]

Barriers and enablers to accessing maternal mental health services by pregnant women

A range of barriers and enablers to maternal mental health care have been reported.[23,39] In lower-middle-income countries particularly, deficiencies in mental care provision for pregnant women in obstetric care settings are commonly encountered due to myriad factors. Table I describes the barriers and enablers to mental health care access among women during pregnancy.

Implications for practice

Midwives and obstetricians can engage pregnant women on their psychological well-being during routine antenatal care services. This can be done through routine screening, careful observations during clinical interactions and establishing therapeutic midwife-patient relationships that create safe environment for disclosure. Validated screening tools such as the Patient Health Questionnaire (PHQ-9) and the Edinburgh Postnatal Depression Scale can be used daily in routine maternity clinics.[41,42] Information on mental disorder symptoms during pregnancy, treatments and available support should be provided to pregnant women and their families for early screening, detection, diagnosis, and treatment. Periodic capacity training on maternal mental disorders for healthcare providers is necessary to create awareness to promote safe motherhood.

Conclusion

Less discussed among midwives and obstetricians, but usually as essential, are maternal mental health issues in the maternity care settings during antenatal visits by pregnant women. Common mental disorders in pregnancy are associated with poor maternal self-care behaviours including antenatal visits reduced to zero and non-compliance to medications. Antenatal depression and anxiety symptoms can effectively be detected and treated early whether mild, moderate or severe with proper guidelines for obstetricians and midwives in obstetric settings. There is a serious need for obstetricians and midwives to take interest in the psychological and emotional well-being of pregnant women. When the adverse effects of mental disorders in pregnancy are identified earlier during routine antenatal visits, patient education and monitoring can be developed to mitigate the impact on maternal and foetal health.[43]

Conflict of interest
The authors declare no conflict of interest.

Funding source
No funding source to be declared.

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